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ABSTRACT

This document is designed to assist the teacher in a nurse assistant certification program. The program is intended to prepare students for entry-level employment in a long-term care facility or with a licensed home health care agency. The 135-hour course teaches basic skills in patient care that will qualify the student to assist the licensed practical nurse or the registered professional nurse in direct patient care. Introductory materials include a bibliography, list of audiovisual resources, and glossary. The course consists of 9 units and 72 lessons. Although the same scope of unit covers all lessons within the unit, a new set of student objectives accompanies each lesson. A lesson title page provides the objectives, supplementary teaching/learning items, teacher resources, and introduction of lesson. Other lesson materials may include an outline with definitions and basic subject matter; procedures for teacher demonstrations; classroom discussion topics or questions; classroom, laboratory, and other activities; evaluation items and answer keys; worksheets; and handouts. Units concern the nurse assistant, the client's environment, the client, safety, food service, personal care, elimination, restorative nursing, and special procedures. Appendixes include federal Medicare regulations, a reprint of Connecticut's Common Core of Learning, and a sample of a contractual agreement for Nurse Assistant Program. (YLB)

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NURSE ASSISTANT

INSTRUCTOR GUIDE

CONNECTICUT STATE DEPARTMENT OF EDUCATION

Adapted from

NURSE ASSISTANT IN A LONG-TERM CARE FACILITY
Instructor Guide
Revised November 1987
with permission
Instructional Materials Laboratory
University of Missouri-Columbia

Augmented to include

HOMEMAKING - HOME MANAGEMENT
as required by the
Connecticut Public Health Code 1988

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NURSE ASSISTANT

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PREFACE

Education of Nurse Assistants is governed by regulations of the Connecticut Public Code, Subsection (1) of Section 19-13-D8t and Section 19-13 D 69. Federal Medicare regulations (Appendix A) were modified in 1988 and specifically addressed the training of Nurse Aides (Nurse Assistants). Connecticut regulations exceed the federal requirements for training Nurse Assistants.

In compliance with statutory regulations, a curriculum outline for the Nurse Assistant Training Program was developed as a coordinated effort between the Department of Health Services, Department of Education, Vocational Technical School System and Board of Higher Education, Regional Community College System. Utilizing this Nurse Assistant Curriculum Outline, a committee of local education agency (LEA) educators, under the auspices of the Bureau of Vocational Services, was formed to develop an in-depth teacher's guide for the high school programs. After reviewing numerous teacher's guides from other states, the Missouri Nurse Assistant in a Long-Term Care Facility Instructor Guide was chosen as the best basic document by the committee which considered it to be well written, comprehensive and presented in an excellent format.

The committee requested and received permission to use the Missouri document which includes graphs and illustrations and adapt it to meet the needs and requirements for the State of Connecticut. The entire guide was reviewed, modified and augmented in order to prepare this material for Connecticut teachers. A great debt of gratitude is owed to the developers of the Missouri Nurse Assistant in a Long-Term Care Facility. Their material is universal in its approach to the education and training of nurse assistants. It would have been a waste of time and effort to re-develop each lesson when it was already so well done. It became the committee's charge to make minor changes in each lesson, rearrange some units and lessons and add units on home health care and home management, mental health, mental illness, developmental disabilities and the life cycle.

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The Committee is grateful for the word processing that was done by Ruth Bottomley, Elaine Lemelin and Angela West.

ORGANIZATIONAL STRUCTURE

I. INTRODUCTION

The purpose of the Nurse Assistant Training Program is to prepare students for entry level employment in a long-term care facility or with a licensed home health care agency. The one-hundred and thirty-five hour course is designed to teach basic skills in patient care which will qualify the student to assist the licensed practical nurse or the registered professional nurse in direct patient care. It focuses on preparing graduates to meet minimum standards for employment and requires continuing on-the-job supervision of the employed certified nurse assistants in nursing care facilities and in home health care agencies.

II. STATEMENT OF PHILOSOPHY

Care givers share a common sensitivity to all human beings. They share a commitment, with other members of the health care team, to help clients overcome ignorance, restore health and maintain wellness. Federal and state laws and regulations are adopted to insure quality care to all clients. This prescribed educational program is designed to include those aspects of learning which will enable students to assist in providing for the physical and emotional needs of the client. The desired goal is the attainment of the optimum degree of independence and wellness of the client.

III. MAJOR COMPETENCIES

Upon successful completion of the program, the student will be able to:

1. Demonstrate knowledge of the health care system and the role of the nurse assistant.
2. Demonstrate knowledge of career opportunities and continuing educational programs in the health field.
3. Demonstrate knowledge of legal and ethical responsibilities of the nurse assistant.
4. Demonstrate knowledge of basic human needs and their relationship to the nurse assistant.
5. Provide a safe and healthful environment for the client.
6. Demonstrate knowledge of basic human anatomy and physiology.
7. Demonstrate knowledge of changes that occur across the life span.
8. Demonstrate knowledge of nutritional needs and food management.
9. Provide personal care and hygiene.
10. Perform special care activities.
11. Assist client with meeting rehabilitation needs.
12. Perform basic household management tasks.
13. Demonstrate effective communication skills and behavior in the clinical and classroom settings.
14. Report and record observations.
15. Demonstrate employability skills.

EDUCATIONAL PROGRAM

I. The local educational agency approved programs for training nurse assistants shall consist of 120 hours of classroom/ laboratory practice and 60 hours of instructor-supervised clinical experience in facilities and agencies that meet the State Department of Health Services requirements for licensure. This document contains the Department of Health Services "basic course" required content for the minimum 75 hours class/laboratory practice and 60 hours of supervised clinical experience. Both the LEA and the adult "basic course" recommend that some portion of the 60 hours of clinical experience be in a home setting.

II. The program shall be taught by a registered professional nurse certified by the Connecticut State Department of Education. The instructor is required to be covered by professional malpractice insurance provided by the school, the facility/agency or the individual. Ideally, the home management component should be taught by a certified home economics teacher. If this is not possible, professionals in specialties such as home economics, dietetics, child development, social service and others, as required to satisfy the Nurse Assistant Curriculum Outline approved by the Department of Health Services, may be invited to teach specific segments.

III. This program is designed to:

   A. Prepare students for entry level employment as nurse assistants in extended care facilities and licensed home health care agencies, according to the Connecticut Public Health Code.

   B. Provide students with a current and accurate picture of the numerous career choices in the health field in order to aid students in matching their abilities with future career choices.

C. Provide students with fundamental knowledge that will enable them to practice sound health measures.

IV. The syllabus' content includes THE NURSE ASSISTANT'S ROLE, THE CLIENT'S ENVIRONMENT, THE CLIENT, SAFETY, FOOD AND NUTRITION, PERSONAL CARE, ELIMINATION, RESTORATIVE NURSING and SPECIAL PROCEDURES including vital signs. This is the basic content for certification. There is no limit to content and instruction beyond this--i.e. career options, expanded anatomy and physiology and employability skills.

Instruction is provided for students in grades 11 and 12 as well as adults if approved by the LEAs.

Each instructor will develop his/her own lessons plans, schedule of classroom and clinical components, calendar of field trips and resource materials. The classroom portion of the program should have no more than a 1-16 ratio. All laboratory and clinical experience must be supervised by the nurse-instructor of the program at the suggested ratio of 1-8 or less.

V. Major competencies must be included in the program to comply with the requirements for certification established by the Connecticut State Department of Health Services regulations.

Within the framework of the major competencies and the particular curriculum content are woven the skills, knowledge and attitudes which are essential to the total development of the individual as presented in the Connecticut's Common Core of Learning. (Appendix B)

VI. Written contractual agreements clarifying areas of responsibility are required between the school district and health care agencies. (Appendix C)

VII. The Vocational Industrial Clubs of America (VICA) is the appropriate student organization for providing leadership training experience and for reinforcing specific vocational skills. When provided, these activities are considered an integral part of the instructional program.

EVALUATION

Evaluation is an essential part of the program. Competency evaluation is required by the Connecticut state regulations.

A. Classroom participation, quizzes, daily assignments, reports, etc.
B. Mid-term and final examinations
C. Performance evaluation sheets

RECORDS

Records are to be maintained.

A. The teacher shall complete and sign the competency record sheet. A record sheet shall be kept of all tests and examinations and shall include scores and comments.
B. A copy of the student's final record shall be provided to the student.
C. The school shall keep the records of the students trained.

CERTIFICATION

I. Certification of nurse assistants is required by Connecticut regulations; therefore, the term "Certified Nurse Assistant" should be used in connection with successful completion of this course. This is an approved LEA program for nurse assistant certification. To be recommended for certification, students must demonstrate satisfactory achievement in the classroom, simulated laboratory and clinical performance based on the professional judgement of the instructor. A student may recieve LEA credit for the program and not be recommended for certification.

II. Certificates are awarded through the LEAs.

III. In compliance with the federal Nursing Home Reform Act, as reported in the Omnibus Budget Reconciliation Reform Act, 1987, the State Department of Health Services must establish a central registry of all Certified Nurse Aides (Assistants) (CNAs).

INFORMATION FOR THE TEACHER

I. It is recommended that the teacher participate in the recruiting, screening and final selection of students who are interested in the program and will be seeking employment after graduation or are planning on further technical education in the health field.

II. Orientation of faculty administrators, guidance personnel and students regarding the program should be a function of the N.A. Program teacher.

III. The teacher will establish a definite time schedule for clinical experience with clinical facilities or agencies and schools. (A block of morning time, a minimum of 3 hours in length, is usually necessary to provide a good learning experience.)

IV. Suitable arrangements for transportation to clinical facilities must be made.

V. The school and clinical facilities must establish policies and procedures regarding student's physical examinations, uniforms, etc.

VI. A plan for assisting in placement of students after certification must be developed.

VII. A plan for continuing evaluation of the program by students, instructor, appropriate staff members of clinical facilities, potential employers, school administrators, graduates of the program, etc., will be used in improving, revising and modifying the program, always following the guidelines.

VIII. The instructor's personal qualifications and teaching ability will be evaluated in accordance with the school district's plan developed in compliance with the state requirements for the evaluation of education personnel, Connecticut General Statutes, Section 10-151(b).

GENERAL INFORMATION REGARDING USE OF THIS MANUAL

I. This document has been prepared to assist the teacher who is instructing in a Nurse Assistant Certification Program.

The familiar "you" is used throughout the document in sections written as material to be presented by the teacher to students.

The abbreviation NA has been used occasionally for brevity to indicate nurse assistant.

II. Throughout this document, the term "client" is used exclusively and can mean "resident" (usually a person hospitalized in a long-term care facility) or "patient" (usually a person hospitalized in an acute care facility) or "client" (usually a person receiving health services outside one of the above-mentioned facilities).

III. Syllabus format: There are nine UNITS and 72 LESSONS. Each UNIT has the same SCOPE OF UNIT with a new set of STUDENT OBJECTIVES (competencies) for each LESSON. For easy use, the following colors are used for identification:

WHITE PAGES: These include LESSON TITLE PAGE, SCOPE, OBJECTIVES, SUPPLEMENTARY TEACHING/LEARNING ITEMS, TEACHER RESOURCES and INTRODUCTION of lesson to students in the familiar form. These are suggestions only. You will add, delete or modify according to your own teaching style. Other WHITE pages are HANDOUTS for the teacher to duplicate for students. Please note that each lesson will indicate if a handout is available with notation (HO).

YELLOW PAGES: OUTLINE (key points) include definitions and basic subject matter for each lesson. It is here that you will note (HO). Answers to the CLASSROOM DISCUSSION (CD) are noted. The lesson ends with a SUMMARY AND CONCLUSION, the conclusion usually being in the familiar form, addressed to the student. Again, this is suggested material to ensure that all topics in the NURSE ASSISTANT CURRICULUM are covered.

GREEN PAGES: STEPS OF PROCEDURES are teacher demonstrations of specific procedures. Some lessons include both lesson OUTLINE (YELLOW) and STEPS OF PROCEDURE (GREEN).

BLUE PAGES: These are CLASSROOM DISCUSSION topics or questions for the teacher to use to interact with students about the previous lesson. The answers, for the most part, are noted in the yellow pages. CLASSROOM, LABORATORY AND OTHER ACTIVITIES are listed here also. Again, these are only suggestions.

PINK PAGES: EVALUATION ITEMS AND ANSWERS TO EVALUATION ITEMS; EVALUATION OF RETURN DEMONSTRATIONS of STEPS OF PROCEDURE.

GREY PAGES: WORKSHEETS to be duplicated for classroom activity.

NOTE: References for each lesson, (TEACHER RESOURCES) listed in the original Missouri document, have been omitted. The original document is available as a resource to you at the office of the Health Occupations Consultant, 25 Industrial Park Road, Middletown, Connecticut 06457, Telephone number (203)-638-4062. The committee has left space under TEACHER RESOURCES for your personal use.

III. The teacher and the LEA have the final decision on the selection of the appropriate text for the students.

IV. The material in this syllabus presents the required content of the Nurse Assistant Curriculum Outline. In some units, the material exceeds the required content. The sequence of presentation is at the teacher's discretion.

V. The teacher will make use of every available support service within the school system to enable students to successfully complete this program.

NOTE TO THE USERS OF THIS MANUAL

I. The committee would appreciate it if you evaluate this syllabus and submit your comments to the Health Occupations Consultant, 25 Industrial Park Road, Middletown, Connecticut 06457.

II. It is the expectation of the committee that, with your assistance, a standard final examination and competency evaluation testing mechanism will be developed. It is hoped that after you have used this teacher's guide for one school year, you will submit a final examination and competency evaluation test. Your submissions will be used to create a test bank for a standard test to be used by the LEAs for certifying nurse assistants.

Enjoy this manual. It has been a wonderful opportunity to create it for your use.

THE COMMITTEE
AUGUST, 1988

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*Suitable texts for Nurse Assistant Secondary Programs

AUDIOVISUAL RESOURCES

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Irvine, CA 92712
(800) 233-7078

Concept Media

5024 Lankershim Blvd.
No. Hollywood, CA 91601
(714) 833-3347

Coronet Instructional Media

65 E. South Water St.
Chicago, IL 60601

Department on Aging

175 Main St.
Hartford, CT 06106

Educare
Care Concepts
Audiovisual In-Service Aids

1101 South Post Oak Rd.
Suite 306
Houston, TX 77056
(713) 627-1881 (Collect)

EIMC Publications

Extension Instruction & Materials Center
University of Texas at Austin
P. O. Box 7218
Austin, TX 78713-7218
(512) 471-7716

Eye Gate House, Inc.

146-01 Archer Avenue
Jamaica, NY 11435

Harris-Tuckman Production, Inc.

751 N. Highland Ave.
Hollywood, CA 90038

Health Care Concepts
Peshak Films, Ltd.

27665 Off Bradley Rd.
Lake Forest, IL 60045

Human Relations Media

175 Tompkins Ave.
Pleasantville, NY 10570
(914) 769-6900

In-Home Care Program
Delmar Publishers, Inc.

2 Computer Drive, West
Box 150115
Albany, NY 12212-5015

Lippincott

East Washington Square
Philadelphia, PA 19105
(800) 523-2945

Medcom-Trainex Corp.

P. O. Box 116
Garden Grove, CA 02642

Media Center
State Fair Community College

1900 Clarendon Rd.
Sedalia, MO 65301
(816) 826-7100

National Innovative Media Co.

Route #2, Box 301B
Calhoun, KY 42327
(800) 962-6662

Para Medical Training Films
Communications Services, Inc.

P. O. Box 8328
St. Louis, MO 63132

Pyramid Films

P. O. Box 1048
Santa Monica, CA 90406

Sunburst Communications

39 Washington Avenue
Pleasantville, NY 10570
(914) 747-3310

Techniques Learning Council

Pasadena, CA 91106

Walt Disney Films

500 South Buena Vista
Burbanks, CA 91521
(800) 423-2555

NOTE:

The Home Economics Department in your school has a list of films which is available on a variety of topics relating to a Nurse Assistant Program. Contact members of the department for advise and suggestions.

0399Z/el

GLOSSARY OF TERMS

A

Abduction - away from the center of the body

Abrasion - a scraping or rubbing off of the skin

Abuse - the infliction of physical, sexual or emotional injury or harm

Activities of daily living (ADL) - any activity that is performed in one's life on a daily basis

Acute - rapid onset, short-term

Adduction - toward the center of the body

Agnosia - loss of the ability to recognize familiar objects

Ambulatory - able to walk

Anterior - toward the front

Anus - outlet of the recturm

Aphasia - inability to speak or write or understand the spoken word due to injury or disease of certain brain cells

Apraxia - loss of the ability to carry out planned movement at will

Asepsis - free of disease-causing microorganisms

Aspiration - to draw a foreign substance into lungs when breathing in

Assault - threat or attempt to injure another in an illegal manner

Assessment - the act of collecting as much information as possible

Atrophy - decrease in size; waste away

Axilla - armpit

B

Battery	- unlawful touching of another person without his/her consent, with or without resultant injury
Bladder	- a muscular sac that stores the urine in the body
Blood pressure	- the amount of force exerted against the walls of an artery by the blood
Body mechanics	- Correct body movement and position of the client and health worker that is efficient and prevents muscle strain
Body temperature	- the amount of heat in the body that is a balance between the amount of heat produced and the amount lost by the body

C

Catastrophic reaction	- overreaction to circumstances
Catheter	- a sterile tube inserted into the bladder to drain urine
Cheyne-Stokes	- a pattern of breathing in which respirations gradually increase in rate and depth and then become shallow and slow; breathing may stop for 10 to 20 seconds
Chronic	- long, drawn out, long-term
Circumcised	- surgical removal of the end of the foreskin of the penis
Client	- person, who, due to aging, disability or illness receives or requires care and services furnished by a facility or home health agency who lives at the facility or in a home setting
Communication	- the exchange of information accomplished by sending and receiving messages
Competency	- the ability to properly perform a specific task
Conduct	- one's actions in general; behavior
Confused	- state of being mixed up
Consent	- permission granted voluntarily by a person in his/her (sound/clear) mind

Constipation - difficult or infrequent movement of the bowels; the passage of unusually dry, hard stools

Constrict - get smaller

Contaminate - to soil, stain or pollute

Contracture - when muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily

Cyanotic - a bluish-gray color of the skin, lips, or nail beds due to lack of oxygen

D

Death - permanent stoppage of all vital functions of the body

Decubitus ulcer - an inflammation, sore or lesion that develops over areas where the skin and tissue underneath are injured due to a lack of blood flow

Defecation - pass feces from the body

Dehydration - loss of body's normal water content which can affect both physical and mental functions

Dementia - severe impairment of cognitive functions such as thinking, memory and personality

Designee - social services representative who is appointed by the resident in writing to take certain responsibilities and receive reports related to a client's personal possessions and property

Developmentally delayed - mental retardation

Diagnosis - the type of disease or medical condition a person has

Diaphoresis - excessive sweating

Diarrhea - frequent passage of liquid stool

Diastolic pressure - the pressure in the arteries when the heart is at rest

Digestion - process by which food is broken down, mechanically and chemically, and changed to a form that can be absorbed by the body

Dilate - to get larger

Discharge - the resident goes to another facility, home or to the home of a relative/friend

Disinfection - chemical or physical agent which kills vegetative form of microorganisms

Disorientation - the state of mental confusion or loss of bearings in relation to the sense of person, place or time

Distention - state of being inflated, enlarged or stretched out

Diversionary - to draw attention to something else or to amuse

Dysphagia - difficulty swallowing

Dyspnea - difficulty in breathing

E

Edema - swelling due to an accumulation of watery fluid in the tissue

Elimination - to rid the body of wastes, such as urine or stool

Emesis - vomiting

Emotion - one's feelings

Ethical - relating to a set of moral principles and values

Ethics - the discipline dealing with that which is good and bad and that which is moral duty and obligation; accepted standards of conduct

Evaluate - to decide if a course of action taken was the correct one

Expectorate - coughing up matter from respiratory tract and spitting it out

Exploitation - illegal or improper use of a person's property or resources to the degree that substantial risk of harm exists

Extension	- to straighten
External	- to turn out away from center
Extremeties	- the arms, legs, hands and feet

F

False imprisonment	- holding or detaining a person against his/her will or without a physician's order
Feces	- waste products of digested food discharged from the intestine (stool, BM)
Flatus	- gas in the bowel
Flexion	- to bend
Flushed	- reddened color of the skin
Footdrop	- contracture of ankle
Foreskin	- loose skin at and covering the end of the penis

G

Gangrene	- death of tissue usually due to deficient or absent blood supply
Goal	- the desired end result, what one hopes to accomplish
Graduate	- a container marked with lines for measuring liquids

H

Halitosis	- bad breath
Hallucination	- sensory perceptions that seem real to the person experiencing them but are not perceived by others
Hemorrhage	- excessive, uncontrolled bleeding
Home Health Care Agency (H.H.C.A.)	- an establishment which provides care and services to clients at home
Hyperextension	- extensive extension

Hypertension	- high blood pressure; persistent BP measurements above the normal systolic (150 mm Hg) or diastolic (90 mm Hg) pressures
Hypotension	- low blood pressure; condition in which systolic BP is below 100 mm Hg and diastolic pressure is below 60 mm Hg

I

Impaction	- hard stool that cannot pass from the rectum normally
Implementation	- carrying out a plan of action
Incontinent	- inability to control evacuation of one's bowels or bladder or both
Infection	- condition in body tissue in which germs have multiplied and destroyed many cells
Inflammation	- reaction of tissue to injury of any kind
Intermediate care facility (ICF)	- a facility which provides 24-hour room, board, personal care and basic health and nursing care services under the daily supervision of a licensed nurse and under the direction of a licensed physician to three or more residents
Internal	- to move in toward center
Invasion of privacy	- a civil wrong that unlawfully makes public knowledge of any private or personal information without the consent of the wronged person

J

Jaundice	- yellow discoloration of skin due to excessive bile in blood

K

Kidneys	- filtering system of the body

L

Labia	- the skin folds which are on both sides of the urethra and vagina
Laceration	- wound produced by cutting or tearing
Lateral	- to the side
Legal	- relating to the law
Libel	- to communicate (in writing) defamatory matter about an individual or group to a third party

M

Malpractice	- "bad practice," professional care that has led to injury due to faulty practice or neglect
Mental illness	- abnormal emotional or behavioral responses
Microorganism	- a very small living thing (a germ)
Mobility	- ability to move
Morals	- your own personal values
Mucus	- sticky substance secreted by mucous membranes mainly in the lungs, nose, and parts of the rectal and genital areas

N

Need	- something essential or desirable that one is lacking or something one feels is lacking
Neglect	- failure of person(s) responsible for an individual to provide necessary services to maintain the physical and mental health of an individual, when such failure presents an imminent or probable danger to the individual
Negligence	- failure to perform in a reasonably prudent manner or by acceptable health care practices
Nocturia	- to urinate during the night
Nutrient	- food that supplies the body with its necessary elements
Nutrition	- the process of taking in food and producing energy from it

O

Obese	- extremely fat
Objective	- way to reach a goal
Obstruction	- a blockage
Orthostatic hypotension	- inability of cardiovascular system to respond quickly enough to body position change causing a drop in blood pressure; often accompanied by dizziness, fainting or falling

P

Pallor	- paleness
Paranoia	- suspiciousness inappropriate to reality
Perineal	- the area between the pubic bone back to and including the anus
Peristalsis	- wave-like movements of the digestive tract which push food along the tract
Perpetrator	- person who inflicts harm
Physical	- relating to the body and the functioning of the body
Plaque	- sticky, transparent bacterial film found on the teeth
Posterior	- toward the back
Postmortem	- after death
Priority	- that which should be considered or done first
Priviledged communication	- any personal or private information which is relevant to a client's care, given by the client to medical personnel
Problem	- needs that a client cannot meet by himself/herself
Projectile	- vomiting forcibly ejected without nausea
Pronation	- to bend downward

Psychological - associated with the thought processes of the brain and behavior

Pulse - the beat of the heart felt at an artery as a wave of blood passes through the artery

Pulse rate - the number of heartbeats or pulses felt in one minute

Purulent - containing pus

Pus - thick yellow/green secretion formed in certain kinds of inflammation

R

Reality orientation - techniques used to assist a person to become aware of the world in which he/she lives

Rehabilitation - restoring of an ill or injured resident so he/she would be able to help himself/herself in A.D.L. as much as possible

Resident - a person who, due to aging or illness, receives or requires care and the services furnished by a facility and who lives at the facility (see client)

Resident (patient, client) care plan - an individual plan of nursing care for each resident, patient or client

Residue - what remains of something after a part is removed

Resistance - ability to fight off

Respirations - act of breathing in and out of the lungs (inhalation/exhalation)

Responsible party - a family member/friend of the client who has been designated in writing by the client to handle matters and receive reports related to the client's general condition

Restorative - returning a client to health or consciousness

Restorative nursing	- the process by which a disabled or ill person is helped to reach the highest possible level of wellness, considering his/her limitations
Rigor Mortis	- temporary rigidity of muscles of the body occurring after death
Rotation	- to move a joint in a circular motion
Roughage	- indigestible fiber of fruits, vegetables and cereal which acts as a stimulus to aid intestinal peristalsis

S

Sanitation	- measures taken to reduce the number of contaminants to a level favorable to health
Scrotum	- the pouch containing the testicles
Seizure	- sudden, violent involuntary contraction of a group of muscles
Skilled nursing facility (SNF)	- a facility which provides 24-hour room, board and skilled nursing care and treatment to at least three clients. Skilled nursing care and treatment services are those performed by or under the supervision of a registered nurse for individuals requiring 24-hour-a-day care by licensed nursing personnel under the direction of a licensed doctor
Slander	- spoken statement of false charges or misrepresentations which defame or damage another's reputation
Social	- relating to human society; getting along with others
Sphincter muscles	- a circle of muscle fibers around the outlet of the urethra and rectum which are normally closed but can be relaxed to allow passage of urine and stool

Sphygmomanometer	- instrument used to measure BP that consists of a cuff which is applied to the upper arm and a measuring device
Sputum	- waste material coughed up from lungs or trachea
Sterile	- free of all living microorganisms
Stethoscope	- instrument used to listen to the sounds produced by the heart, lungs and other body organs
Strategy	- a plan or method
Sundowning	- phenomena when behavior problems become worse in evening
Supination	- to bend upward
Supine	- lying on one's back
Suppository	- A semisolid substance that may contain medicine that can be inserted into the rectum or vagina where it dissolves
Systolic pressure	- amount of force it takes to pump blood out of the heart into the arterial circulation

T

Terminal disinfection	- thorough cleaning of room with disinfectant solution after isolation is discontinued
Toxin	- a poisonous substance
Transmitted	- transferred or spread
Tact	- saying and doing the right thing without hurting feelings of others

U

Unconscious	- lacking in awareness of the individual
Ureters	- tubes that carry urine from kidneys to bladder
Urethra	- the small passage from the bladder through which urine leaves the body
Urinate	- to pass urine (also micturate or void)

V

Value system - behavior related to a pattern of conduct or ideas that are accepted as worthwhile or meaningful

Ventilate - give air to

Void - to pass urine (see urinate)

Vital signs - temperature, pulse, respirations and blood pressure; signs of life

W

Wandering - aimless walking which may result in a resident becoming lost

LESSON PLAN: 1

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant --general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-1 OR DEMONSTRATION:

BECOMING A NURSE ASSISTANT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List seven goals of the course.
3. Identify requirements of the course.
4. Establish effective study habits.
5. Identify four factors that help a nurse assistant become successful.
6. Identify four personal qualities of the nurse assistant.
7. Identify two ways to organize work.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Successful Nurse Assistant
2. HO 2: Nurse Assistant Assignment Sheet
3. Sample evaluation tools
4. Selected references (including dictionaries)
5. Facility evaluation form

TEACHER RESOURCES:

INTRODUCTION:

This course is designed for the nurse assistant who will be or is currently employed in a long-term care facility or home care setting. It is designed to meet the requirements stated in the laws and regulations of the state of Connecticut for nursing home licensure and home health care agency licensure.

This course will prepare you to deliver safe, effective client care and help you obtain the necessary knowledge to become qualified as a certified nurse assistant as required by law.

LESSON PLAN: 1

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Competency - the ability to properly perform a specific task.

B. Evaluate - to decide if a course of action was the correct one to take.

C. Goal - the desired end result; what one hopes to accomplish.

D. Home Health Care Agency (H.H.C.A) - an establishment which provides care and services to clients in the home.

E. Intermediate Care Facility (ICF) - a facility which provides 24-hour room, board, personal care and basic health and nursing care services to at least 3 clients under the daily supervision of a registered nurse (R.N.) and under the direction of a licensed doctor.

F. Objective - way to reach a goal.

G. Priority - that which should be considered or done first.

H. Client - a person who, due to aging, disability or illness, receives or requires care and services furnished by a facility or home health agency and who lives at the facility or at a home setting. (Term "client" will be used throughout this document. Term "patient" or "resident" may be inferred).

I. Skilled Nursing Facility (SNF) - a facility which provides 24-hour room, board, and skilled nursing care and treatment to at least three clients. Skilled nursing care and treatment services are those performed by or under the supervision of a registered nurse for individuals requiring 24-hour-a-day care by licensed nursing personnel under the direction of a licensed doctor.

J. Strategy - a plan or method.

II. Goals of the Nurse Assistant Course (CD-1)

A. Develop good personal habits.

B. Recognize the nurse assistant's role as it fits into the organizational structure of a long-term health care facility and home health agency.

C. Identify responsibilities of the nurse assistant to the client and the health care team.

D. Demonstrate basic skills and techniques in performing uncomplicated nursing procedures according to the program standards.

E. Organize and administer nursing care to clients based on a plan of care and/or direction from charge personnel.

F. Demonstrate knowledge of client's rights in assisting clients with their activities of daily living.

G. Demonstrate ability to assist the handicapped clients to return to their best health potential.

III. Course Requirements

A. Qualification of students

1. Any individual deemed suitable for provision of direct client care in a long term care facility or home health agency.

2. 16 years of age or currently enrolled in a secondary health services occupations program in an area vocational-technical school, a comprehensive high school or community college.

B. Educational program of the nurse assistant

1. The basic program consists of a minimum of 75 hours of classroom/laboratory instruction.

2. 60 hours on-the-job clinical practice will be completed by each student under the supervision of an RN. The RN instructor shall provide documentation that the 60 hours have been completed prior to final testing.

3. Final written and practical examination based on course objectives given by an RN instructor.

4. Evaluation of the program will be requested from the students and the health care facility employers.

C. Classroom strategies

   1. Lectures giving an overview of material
   2. Use of student guide (includes most handouts)
   3. Use of references
      a. Textbooks
      b. Periodicals
      c. Pamphlets
   4. Demonstration of procedures by instructor and return demonstration by student
   5. Audio-visual materials - films, filmstrips, slide/tapes
   6. Evaluation
      a. Evaluation check-sheets for procedural demonstrations
      b. Classroom discussion
      c. Written and practical tests
   7. Records shall be made available to the NA.

IV. Study Habits (CD-2)

A. Surroundings

   1. Quiet, without interruptions
   2. TV or radio is distractive

B. Studying assigned material

   1. Read material as soon as possible after class.
   2. Fill in notes.
   3. Use topic headings or key sentences.
   4. State the content or ideas in your own words.
   5. Underline the important words, sentences, or phrases.
   6. State topic aloud.
   7. Complete assignments as soon as possible after class

C. Test yourself.

   1. Answer written objectives on first page of lesson plan.

   2. Construct your own test questions.

D. Reference materials

   1. Use a library, if available.

   2. Look up new words in the dictionary or refer to glossary.

E. Taking a test

   1. Read the question quickly but thoroughly. Read each word of the question and all choices (if multiple choice).

   2. Select the answer you believe is correct--usually your first thought is correct. Never erase or change an answer unless you are positive your first choice is wrong.

   3. Restate each question in your own words.

   4. Look for key words - always, never, all, none, etc.

V. Qualities of the Successful Nurse Assistant (HO 1) (CD-3)

A. Take pride in your personal appearance.

   1. Bathe daily and use deodorant, particularly during menstruation.

   2. Prevent bad breath by brushing teeth.

   3. Keep fingernails short, trimmed, and clean.

   4. Keep hair neat and clean, in a simple style, out of the eyes, and not touching the collar; long hair must be pinned up so loose hairs do not spread germs.

   5. Always wash hands after using bathroom facilities.

B. Be aware that your own good health makes it easier to provide care to others.

  1. Eat a well-balanced diet.

  2. Acquire adequate sleep and relaxation.

  3. Cope with stress (inner pressure) in a positive way.

  4. Practice good body posture.

  5. Never take alcohol or illegal drugs before work or while on duty.

  6. Prevent disease by:

    a. Proper handwashing

    b. Immunizations

    c. Health maintenance program

C. Dress appropriately for the job.

  1. Wear uniform of modest length or pantsuit uniform that is clean, pressed, and mended as needed.

  2. Change lingerie and underclothing daily; undergarments should provide good support.

  3. Jewelry is not considered part of any uniform (check policy of the facility).

    a. Wedding band only - stone settings can trap germs, scratch the resident or get damaged.

    b. Small earrings - dangling earrings can be pulled at

  4. Change stockings daily (color determined by facility policy).

  5. Shoes should be comfortable and provide support.

    a. Clean and polish shoes as needed to maintain neat appearance.

    b. Shoestrings should be clean; wash as needed.

  6. Makeup - use in moderation

  7. Perfume should be used in moderation, if at all. Too much can be offensive to others.

(CD-4)

D. Develop personal qualities that demonstrate your ability to care for others.

1. Sensitivity - awareness of attitudes and feelings of others; knowing when a person feels uncomfortable, lonely, scared, etc.
2. Patience - ability to remain calm even when demands are heavy or seem unreasonable
3. Honesty - always truthful and genuine
4. Cheerfulness - having a pleasant and happy nature; smiles frequently
5. Willingness to learn and help others
6. Observation skills - always on the lookout for anything unusual or significant
7. Reliability - dependability; ability to perform duties without fail
8. Positive attitude - sense of enjoying your job and ability to integrate the above qualities into your work
9. Tact - sense of what to do or say in order to avoid offense

VI. Organize your work

A. Identify priorities. (CD-5)

1. Make quick rounds of your assigned area when coming on duty; this will assist you in determining which clients need immediate attention and which ones can wait.
2. Use a work sheet to copy assignments. If you forget what needs to be done, a quick glance at the sheet in your pocket will remind you. (HO-2)

B. Utilize your time properly.

1. make a list of things to be done according to policy and procedure of the facility or home health care agency.
2. Plan ahead - organize supplies and equipment for the day. Example: lay out clothes while making rounds so they will be ready at bath time.

3. Gather all equipment needed before starting a procedure.

4. Work together with co-workers.

    a. Make beds together, team up to turn residents, etc.

    b. Plan together on use of showers and equipment.

5. After taking care of immediate needs of clients as determined in the first round, take care of your most difficult client's needs first--this can give you a sense of accomplishment and help organize your time more efficiently.

VII. Summary and Conclusion

A. Terms and definitions

B. Goals of the nurse assistant course

C. Course requirements

D. Study habits

E. Qualities of the successful nurse assistant

F. Organizing your work

You should now be aware of the differences between a goal and an objective, and be informed of the goals for this course. Each individual has his/her own way of studying but keep in mind some of the helpful hints provided. Always think about your outer and inner appearance. You are entering a field of work that requires you to be around people constantly. Thus you need to be skilled at getting along well with everyone.

LESSON PLAN: 1

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What do you think the goals of this course would be?
2. What would you include in your plan to strengthen your study skills?
3. Why does the way you dress and look affect the way people act toward you?
4. What are some personal qualities that demonstrate the nurse assistant's ability to care?
5. What does priority mean?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Have students role-play situations which illustrate qualities of the nurse assistant, such as being dependable, or someone with a positive versus a negative attitude.
2. Bring the facility's evaluation forms to class; make up a personnel file on a poor employee and discuss with students.
3. Have students write the seven goals of this course in their own words.

LESSON PLAN: 1

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

______ 1. Client

______ 2. Competency

______ 3. Evaluate

______ 4. Goal

______ 5. H.H.C.A.

______ 6. ICF

______ 7. Objective

______ 8. Priority

______ 9. SNF

______ 10. Strategy

a. Person who requires care and services furnished by a facility or H.H.C.A. because of aging, disability or illness; lives in the facility or at home.

b. That which should be considered or done first

c. The ability to properly perform a task

d. The desired end result; what one hopes to accomplish

e. A facility providing 24-hour room, board, personal care and basic health and nursing care services under the daily supervision of a licensed nurse and under the direction of a licensed doctor to three or more clients

f. A plan or method

g. To decide if a course of action was the correct one to take

h. A facility providing 24-hour room, board, and skilled nursing care and treatment to at least three clients under the supervision of a registered nurse for individuals requiring 24-hour-a-day care by licensed nursing personnel

i. A way to accomplish a desired end result

j. An establishment which provides care and services to clients in a home setting.

11. List the seven goals of the nurse assistant course.

a.

b.

c.

d.

e.

f.

g.

12. What is the total number of hours required to complete this course?

13. List four personal qualities of the successful nurse assistant.

a.

b.

c.

d.

14. List two ways to improve the way you use your time at work.

a.

b.

For each of the following, write "T" if the statement if true, or "F" if it is false.

______15. The Final practical exam is given by the instructor of the course.

______16. The study environment should be quiet.

______17. When selecting an answer to a test question, usually your first thought is correct.

______18. Long, loose hair can be a source for spreading germs while caring for residents.

______19. It is acceptable to be a few minutes late if your co-workers always come in late.

_______20. Identifying priorities and utilizing time properly will help organize your work.

_______21. The successful nurse assistant is the one who has all of these qualities except: (Circle the letter of the correct answer).

a. Knows the importance of staying in good health
b. Takes pride in his or her personal appearance
c. Performs the job in a negative manner and does not care what others think
d. Dresses appropriately for the job

LESSON PLAN: 1

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1.a
2.c
3.g
4.d
5.j
6.e
7.i
8.b
9.h
10.f

11. a. Develop good personal habits.

    b. Recognize the nurse assistant's role as it fits into the organizational structure of a long-term health care facility.

    c. Identify responsibilities of the nurse assistant to the client and the health care team.

    d. Demonstrate basic skills and techniques in performing uncomplicated nursing procedures according to the program standards.

    e. Organize and administer nursing care to clients based on a plan of care and/or direction from charge personnel.

    f. Demonstrate knowledge of client's rights in assisting clients with their activities of daily living.

    g. Demonstrate ability to assist the handicapped clients to return to their best health potential.

12. A minimum of 135, including 75 hours of classroom/laboratory instruction and 60 hours of on-the-job clinical practice.

13. The student may list any four of the following:

    a. Sensitivity
    b. Patience
    c. Honesty
    d. Cheerfulness
    e. Willingness to learn and help others
    f. Observation skills
    g. Reliability
    h. Positive attitude

14. The student may list any two of the following:

    a. Make a list of things to be done according to policy and procedure of the facility.

    b. Plan ahead - organize supplies and equipment for the day.

    c. Gather all equipment needed before starting a procedure.

    d. Work together with co-workers.

        1. Make beds together, team up to turn clients, etc.

        2. After taking care of immediate needs of clients as determined in the first round, take care of the most difficult client's needs first.

15. T
16. T
17. T
18. T
19. F
20. T
21. C

THE SUCCESSFUL NURSE ASSISTANT

HO 1

Is Sensitive, Patient, and Honest

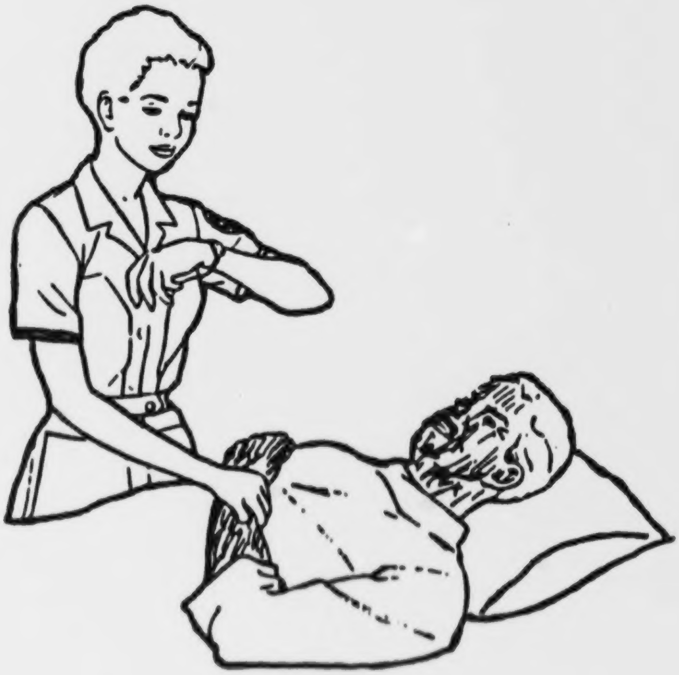
Is Cheerful, Willing to Help Others, and Observant

Practices Good Personal Hygiene

Is Reliable and Maintains a Positive Attitude

Maintains Appropriate Dress and Appearance

Practices Good Personal Health



NURSE ASSISTANT ASSIGNMENT SHEET

HO 2

NURSE ASSISTANT ASSIGNMENT SHEET

N.A. ____________________

DATE ____________________

ROOM	NAME	I & O	TPR/B/P	B.T.	TURN	MISC.

NURSE ASSISTANT ASSIGNMENT SHEET

N.A. ____________________

DATE ____________________

ROOM	NAME	I & O	TPR/B/P	B.T.	TURN	MISC.

LESSON PLAN: 2

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-2 OR DEMONSTRATION:

THE HEALTH CARE TEAM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Match selected health care team members with their major responsibilities in a long-term care facility and Home Health Care Agency.
3. Describe the lines of authority the nurse assistant should follow.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Health Care Team
2. Trainex filmstrip #406: "Orientation: Joining the Health Care Team"
3. Projector

TEACHER RESOURCES:

INTRODUCTION:

The term "health care team" is another way of describing the process by which people join together to diagnose, plan for, give care to, and rehabilitate those individuals with illnesses, injuries, or infirmities who require long-term care. The concept of the health care team is based on the fact that it takes more than one or several individuals to provide effective client care. In this lesson you will learn about the individuals on the health care team, their specific responsibilities, and how the nurse assistant relates to these team members. In addition, we will review the lines of authority the nurse assistant must follow in all care assignments.

LESSON PLAN: 2

COURSE TITLE: NURSE ASSISTANT

UNIT I: THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Activities of daily living (A.D.L.) - any activity that is performed in one's life on a daily basis

B. Designee - social services representative who is appointed by the client in writing to take certain responsibilities and receive reports related to a client's personal possessions and property

C. Diagnosis - the type of disease or medical condition a person has

D. Elimination - to rid the body wastes, such as urine or stool

E. Emotion - one's feelings

F. Mobility - ability to move

G. Physical - relating to the body and the functioning of the body

H. Psychological - associated with the thought processes of the brain and behavior

I. Reality orientation - techniques used to assist a person to become aware of the world in which he/she lives

J. Rehabilitation - restoring of an ill or injured client so he/she would be able to help himself/herself in A.D.L. as much as possible.

K Responsible party - a family member/friend of the client who has been designated in writing by the client to handle matters and receive reports related to the client's general condition

L Restorative - returning a client to health or consciousness

M Social - relating to human society, getting along with others

II. Health Care Team Members (HO-1)

A. Client and his/her family have particular needs which must be identified by team members

B. Physician (M.D.)

1. Makes a diagnosis

2. Gives orders for medication and treatment

3. Guides plan of care

C. Administrator - responsible for all aspects of operation of the long-term care facility and H.H.C.A. including delivery of proper client care

D. Director of Nurses - responsible for supervision, provision and quality of nursing care

E. Nursing staff (CD-1)

1. Registered nurse (RN)

a. Length of training is two to four years

b. Must pass a state board of nursing examination upon completion of educational program

c. Duties

1) Plans and assigns nursing care

2) Responsible for all team members working together

3) Reviews quality of care

4) Gives medication

5) Starts IV's

6) Assists with client care (physical, psychological and social)

7) Takes and records physician's telephone and verbal orders

8) Teaches nursing procedures

9) Administers tube feedings

2. Licensed practical nurse (LPN)
    a. Length of training is one year
    b. Must pass a state board of nursing examination upon completion of educational program
    c. Duties
        1) Plans, assigns, and evaluates nursing care
        2) Gives medication under direction of a Registered Nurse
        3) Assists with client care (physical, psychological and social)
        4) Takes and records physician's telephone and verbal orders
        5) Performs most treatments
        6) Administers tube feedings
3. Nurse assistant (NA)
    a. Length of training is a minimum of 75 hours of classroom and 60 hours of on-the-job training and final exam.
    b. Final exam is passed before qualification.
    c. Future employment opportunities are discussed.
        1) Acute Care Hospital
        2) Intermediate Care Facility
        3) Skilled Care Facility
        4) Home Health Care Agency
        5) Variety of Health Care Delivery Systems
    d. Duties
        1) Provides for and assists with activities of daily living
        2) Provides personal care which includes selected procedures under the direction and supervision of the charge nurse
            a) Feeding
            b) Dressing

            - c) Bathing
            - d) Measuring and recording vital signs
            - e) Weighing and measuring client
            - f) Bowel and bladder retraining
            - g) Reality orientation
            - h) Maintaining safe environment
            - i) Transferring to chairs/beds
            - j) Transferring client to activities planned by the activities director
        - 3) Makes accurate observations and reports to charge nurse
        - 4) Helps meet the emotional needs of the client
            - a) Aware of client's emotional needs; alerts social services designee of problem through chain of command
            - b) Is an effective communicator
        - 5) Performs homemaking/home management activities
            - a) Plans and prepares meals
            - b) Maintains clean, safe environment

E. Dietary employees

- 1. Dietitian (usually a consultant)
    - a. Consults with dietary/food service supervisor
    - b. Approves menus, evaluates, and counsels clients with nutritional problems
- 2. Dietary/food service supervisor (long term care only)
    - a. Manages dietary department (orders supplies, foods, etc.)
    - b. Interviews clients
    - c. Supervises dietary employees

3. Dietary staff (ICF and SNF only)
    a. Prepares and may serve food
    b. Washes dishes
    c. Keeps dietary area clean

F. General housekeeping and maintenance (ICF and SNF only)
  1. Housekeeping employees
    a. Provides daily room care
    b. Cleans all other areas of facility
  2. Laundry employees
    a. Launders linen, bedding, and clothing
    b. Mends items as necessary
  3. Maintenance employees - general repair and grounds keeping
  4. Homemaker - general home management duties

G. Activities director (ICF and SNF only)
  1. Conducts group and individualized activities so that each client of the facility is reached
  2. Supervises volunteers
  3. Schedules community sponsored activities in the facility

H. Physical therapist; occupational therapist; speech therapist (usually consultants)
  1. Plans and provides therapy essential to promote rehabilitation based on physician's orders
  2. Instructs staff in restorative nursing procedures

I. Social services (designee)
  1. Screens clients prior to admission to a facility or discharge to home to determine if the individual client's needs can be met
  2. Meets client's needs
    a. Assists with admission process - reviews rights and responsibilities of client and facility

b. Counsels

1) Has contact with client to determine if social and emotional needs are being met

2) If qualified, provides individual or family counseling-- otherwise refers for assistance for qualified professional

c. Personal services

1) Financial resources - assists with insurance forms, pensions, social security, etc.

2) Secures aids to daily living (wheelchairs, canes, etc.)

3) Arranges for outside services to meet client's needs

3. Discharge planning

a. Referrals (home health care agency, another long-term health care facility, hospital)

b. Follow-up

III. Chain of Command (CD-2)

A. If the nurse assistant observes or suspects a problem, he/she should direct this concern to the next responsible person (immediate supervisor) and then follow each successively higher level of the chain of command until the problem is resolved.

B. Charge nurse (RN or LPN) is next in command

C. Director of Nurses is next

D. Administrator is the health care team member with the most responsibility and ultimate authority

IV. Summary and Conclusion

A. Terms and definitions

B. Health care team members

C. Chain of command

The most important members of the health care team is the client and his/her family. All team members must join together to identify and meet each client's needs. They must communicate well with one another to give the best care possible. As a nurse assistant, you must be aware of the lines of authority you are required to follow when a problem arises.

LESSON PLAN: 2

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What are some differences between RN, LPN, and NA?
2. If you encountered a problem which you felt was severe and needed attention, to whom would you talk first?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Divide class into two groups. Assign titles of health care team members to each group. Have students prepare clues that will identify who the team member is. The other team then guesses who the member is based on the clues.
2. Have students role-play different levels of authority
    a. Remind a staff member to do his/her job.
    b. Reprimand someone for consistently being late.
    c. Deal with a staff member who has not followed the chain of command while trying to solve a problem.
3. Show filmstrip.
4. Flash cards: Jobs and Duties

LESSON PLAN: 2

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_______ 1. Activities of daily living

_______ 2. Designee

_______ 3. Diagnosis

_______ 4. Elimination

_______ 5 Emotion

_______ 6. Mobility

_______ 7. Physical

_______ 8. Psychological

_______ 9. Reality orientation

_______10. Rehabilitation

_______11. Responsible party

_______12. Restorative

_______13. Social

a. Relating to the body of and the functioning of the body.

b. A person (family member/friend), appointed by the client in writing, to take certain responsibilities and receive reports related to a client's personal possessions and property

c. A family member/friend of the client designated in writing by the client to handle matters and receive reports related to the client's general condition

d. Any activity that is performed in one's life on a daily basis

e. One's feelings

f. Associated with the thought process of the brain

g. Finding out what kind of disease or medical condition a person has

h. Relating to human society, getting along with others

i. Restoring of an ill or injured client so he/she would be able to help himself/herself as much as possible

j. To rid the body of wastes, such as urine or stool

k. Ability to move

l. Techniques used to assist a person to become aware of the world in which he/she lives

m. Returning a client to health or consciousness

14. Which one of the following best describes the responsibility of the nurse assistant? (Circle the letter of the correct answer.)

    a. Plans and assigns nursing care
    b. Provides patient bedside care under the supervision of a nurse
    c. Assumes responsibility for all team members
    d. Administers medications

15. An L.P.N. asked you to give some of her a.m. meds on several occasion. Who would you talk to about this? (Circle the letter of the correct answer.)

    a. Another nurse assistant
    b. The administrator
    c. The physician
    d. The charge nurse

Match the following health care team members with one responsibility associated with their job titles by writing the letter in the blank.

16. Activities director

17. Administrator

18. Dietary staff

19. Director of nurses

20. Nurse assistant

21. Nurse (RN/LPN)

22. Physician

23. Social service designee

a. Plans and assigns nursing care

b. Writes orders for medications and treatments

c. Provides bedside nursing care

d. In charge of the facility

e. Prepares and serves food

f. Plan social events for the facility

g. Helps resident with admission, discharge, and personal affairs

h. Responsible for all nursing services for the whole agency or facility

24. Another N.A. is smoking in a non-smoking area. She refuses to stop at your request. To whom will you report this?

25. List 3 employment opportunities for a N.A.

LESSON PLAN: 2

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

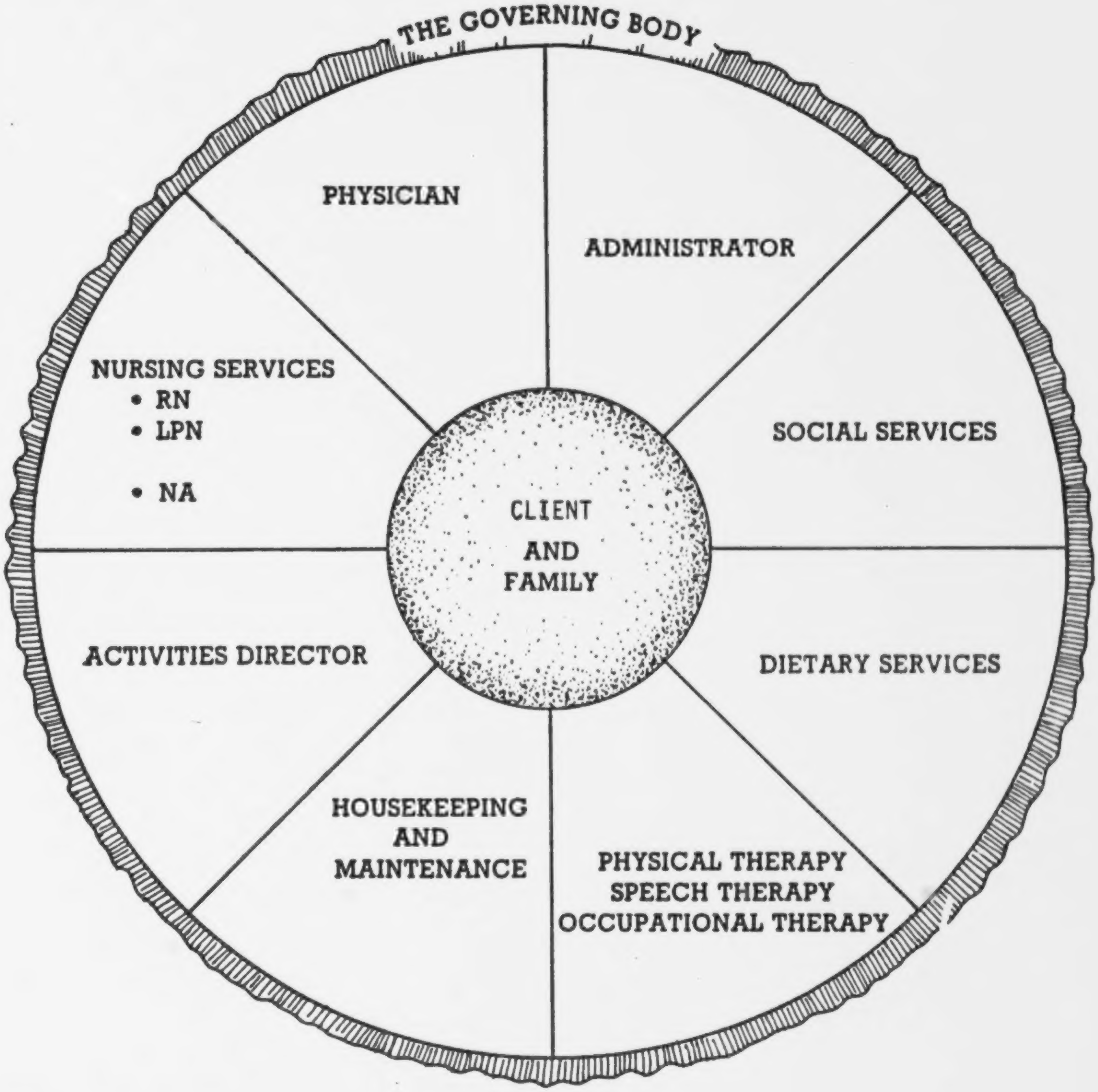
ANSWERS TO EVALUATION ITEMS:

1. d
2. b
3. g
4. j
5. e
6. k
7. a
8. f
9. l
10. i
11. c
12. m
13. h
14. b
15. d
16. f
17. d
18. e
19. h
20. c
21. a
22. b
23. g

24. The student should indicate she would report the incident to charge nurse

25. H.H.C.A.
    or
    Acute Care Hospital
    or
    S.N.F.
    or
    I.C.F.

THE HEALTH CARE TEAM


THE GOVERNING BODY
PHYSICIAN
ADMINISTRATOR
NURSING SERVICES
• RN
• LPN
• NA
SOCIAL SERVICES
CLIENT AND FAMILY
ACTIVITIES DIRECTOR
DIETARY SERVICES
HOUSEKEEPING AND MAINTENANCE
PHYSICAL THERAPY
SPEECH THERAPY
OCCUPATIONAL THERAPY

LESSON PLAN: 3

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-3 OR DEMONSTRATION:

ETHICAL AND LEGAL RESPONSIBILITIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify techniques of proper documentation.
3. List six client's rights.
4. Identify who should be notified if abuse, neglect, or exploitation is suspected.
5. List five areas of information needed when reporting an abuse, neglect, or exploitation case.
6. Define the term "grievance".

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Client's Rights (Patient's Rights)
2. Facility's or Homemaker Home Health Care Agency's Policy Manual -- "Grievance Procedure"

TEACHER RESOURCES:

INTRODUCTION:

As an employee in the health care occupations, it is important for you to be aware of your legal and ethical responsibilities to prevent any medical or legal problem from developing. When functioning as a nurse assistant, you are responsible and accountable for your own actions. There is a possibility that you may be sued and taken to court by a client and/or his/her family if you do not perform your job in a safe and proper manner. Therefore, you must be aware of state laws, rules, and certain legal terms and what they mean.

"Legal" relates to the law and "ethical" relates to a set of moral principals and values. When you serve clients in any way or have access to their records you are expected to maintain their confidence and trust. Any violation of the client's confidence may be defined as an illegal or immoral act.

There are certain laws which protect clients while in a health care facility. The client voluntarily signs an admission agreement giving his/her consent for treatment and care, but the client has the right to refuse treatment unless he/she has been determined legally incapacitated.

The problem of abuse, neglect and exploitation is also addressed in the Connecticut State Statutes of 1978 46A-15. We will be discussing what these terms mean, as well as what to do if you believe a client is being violated in such a way.

LESSON PLAN: 3

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Ethical - relating to a set of moral principles and values

B. Legal - relating to the law

C. Ethical terms

1. Ethics - the discipline dealing with that which is good and bad and that which is moral duty and obligation; accepted standards of conduct

2. Conduct - one's actions in general; behavior

3. Value system - behavior related to a pattern of conduct or ideas that are accepted as worthwhile or meaningful

4. Morals - your own personal values

D. Legal terms

1. Abuse - the infliction of physical, sexual or emotional injury or harm

   Example: slapping a client

2. Assault - threat or attempt to injure another in an illegal manner

   Example: telling a client, "If you don't be quiet, I'll tie your hands down."

3. Battery - unlawful touching of another person without his/her consent, with or without resultant injury

   Example: Carrying out the above threat

4. Consent - permission granted voluntarily by a person in his/her (sound/clear) mind

5. Exploitation - illegal or improper use of a person's property or resources to the degree that substantial risk or harm exists

6. False imprisonment - holding or detaining a person against his/her will or without a physician's order

   Example: Applying restraints without obtaining a physician's order

7. Invasion of privacy - a civil wrong that unlawfully makes public knowledge of any confidential or personal information without the consent of the wronged person

   Example: Discussing with a friend the care of a client which involves personal information, without the permission of the client

8. Libel - to communicate (in writing) defamatory matter about an individual or group to a third party

   Example: Writing on the client's chart "The client was a cross, old crackpot today."

9. Malpractice - "bad practice," professional care that has led to injury due to faulty practice or neglect

   Example: Observing daily that a wound is becoming more severe and not reporting it to the charge nurse

10. Neglect - failure of person(s) responsible for an individual to provide necessary services to maintain the physical and mental health of an individual, when such failure presents an imminent or probable danger to the individual

11. Negligence - failure to perform in a reasonably prudent manner or by acceptable health care practices

    Example: leaving bed-side rails down on a bed occupied by a confused client which results in the client's falling out of bed

12. Perpetrator - person who inflicts harm

13. Privileged communication - any personal or private information which is relevant to a client's care, given by the client to medical personnel

14. Slander - spoken statement of false charges of misrepresentations which defame or damage another's reputation

    Example: Stating that a client is a "crazy old woman and out of control" to your friend who knows the client

II. Documentation (CD-1)

A. Remember--the chart is a legal document accepted in court of law.

B. Be objective--chart only what is seen, heard, felt, smelled, etc., do not write your own opinions.

C. Use ink at all times since it a permanent record.

D. Follow proper charting form, spell correctly.

III. Client's Rights (HO-1) (CD-2)

INSTRUCTOR NOTE: Discuss handout 1 in class, reviewing each of the seventeen rights listed.

A. The client has rights just as you do.

B. Each facility and agency should have a section in the policy and procedure manual that explains how each client's rights are to be implemented and ensured.

IV. Abuse, Neglect and Exploitation Reporting

A. Abuse, neglect or exploitation may be perpetrated by:

1. Staff members - NA, LPN, RN, dietary or maintenance personnel, etc.
2. Family members
3. Visitors
4. Other clients

B. Physical signs of abuse (CD-3)

1. Burns in unusual locations
2. Bruises on both upper arms
3. Bruises resembling an object
4. Bruises on trunk from repeated striking
5. Broken eyeglasses - lens or frames
6. Cuts/welts/black eye
7. Anything that appears suspicious should be reported

C. Behavioral signs of emotional abuse

1. Sudden change in behavior

2. Withdrawal

3. Lack of complaints

D. Physical signs of neglect

1. Unkempt appearance

2. Untrimmed nails

3. Signs of dehydration

4. Weight loss

5. Pressure ulcers

E. Exploitation - to protect the client, laws exist that prohibit the acceptance or solicitation of money or any item having monetary value from the resident. This includes:

1. Staff of the facility or H.H.C.A.

2. Volunteers at the facility or H.H.C.A.

3. Other clients

F. If you suspect abuse, neglect, or exploitation notify a person in authority who will make the official complaint to the appropriate state agency.

V. Grievance Procedure

A. Grievance - a cause of distress which justifies complaint or resistance

B. May be filed by a client or employee

C. Grievance procedure for facility or agency should be outlined in writing and appear in that facility's or agency's policy manual; please refer to it.

VI. Summary and Conclusion

A. Terms and definitions

B. Documentation

C. Client's rights

D. Abuse, neglect, and exploitation reporting

E. Grievance procedure

The NA can prevent legal and ethical problems from developing while caring for clients by remembering the following rules:

1. Remember the client is your responsibility while you are in charge of his/her care.
2. Be aware of the client's rights and avoid violating them.
3. Prepare all paperwork correctly.
4. Know the lines of authority--do only those things which you have been trained and supervised to do.
5. Do not give personal information about a client over the telephone--refer all calls to the nurse.
6. Do not discuss with others (either in the facility or outside) a client's behavior, medical condition, or his/her personal matters.

LESSON PLAN: 3

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. Can you think of any other examples of legal problems?
2. What rights does the client have?
3. What are some physical signs of abuse or neglect?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Role-play some situations which involve legal/ethical conduct:
    a. You have just witnessed a co-worker slap a client who is resisting her efforts to get him to bed.
    b. One of your clients is making repeated attempts to go out-of-doors. In order to keep him safe while you give care to another, you tie him to a chair.
2. Role-play some situations that involve client's rights:
    a A visitor has just given a client a $20 bill. You know this confused person cannot manage it safely.
    b. A husband is visiting his wife who is a client. The door to the room is closed, and you need to deliver fresh water.
    c. You are a client who receives personal mail that has been opened.

LESSON PLAN: 3

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_______ 1. Assault

_______ 2. Battery

_______ 3. Conduct

_______ 4. Ethics

_______ 5. False Imprisonment

_______ 6. Libel

_______ 7. Negligence

_______ 8. Slander

a. Verbally threatening to hurt someone

b. One's actions in general

c. Failure to perform in an acceptable manner

d. The discipline dealing with that which is good and bad

e. Telling something false about someone

f. Writing defamatory matter about an individual

g. Unlawful touching of another person without his/her consent, with or without injury

h. Holding someone against his/her will

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 9. A chart is a legal document.

_______10. Charting with a pencil is acceptable practice.

Match the following terms to correct definitions by writing the letter in the blank.

______11. Exploitation	a. The infliction of physical, sexual, or emotional injury or harm
______12. Abuse	b. Failure to adequately take care of a person causing danger to him/her
______13. Neglect	c. Illegal or improper use of person's property to the degree that substantial risk or harm exists.

14. List six rights the client has.

a.

b.

c.

d.

e.

f.

15. Who do you notify if you suspect abuse, neglect, or exploitation?

16. List five areas of information needed when reporting an abuse neglect, or exploitation case.

a

b

c.

d.

e.

17. Define the term grievance.

LESSON PLAN: 3

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. a
2. g
3. b
4. d
5. h
6. f
7. c
8. e
9. T
10. F
11. c
12. a
13. b

14. The student may list any six of the rights contained in HO 1: Client's Rights from this lesson.

15. The NA should notify the next person in authority.

16. a. Name and address of client
    b. Name and address of the facility
    c. Nature and extent of victim's condition or nature of abuse or neglect
    d. Name of person making report or complaint
    e. Name of alleged perpetrator

17. A grievance is a cause of distress which justifies compliant or resistance.

EXAMPLE OF A NURSING CARE FACILITY'S

PATIENT'S RIGHTS

Each patient admitted to this facility:

1. is fully informed as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities
2. is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate
3. is fully informed, by a physician, of his/her medical condition unless medically contraindicated (as documented by a physician in his/her medical record), and is afforded the opportunity to participate in the planning of his/her medical treatment and to refuse to participate in experimental research
4. is transferred or discharged only for medical reasons, or for his/her welfare or that of other patients, or for non-payment for his/her stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his/her medical record
5. is encouraged and assigned throughout his/her period of stay, to exercise his/her rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his/her choice, free from restraint, interference, coercion, discrimination, or reprisal
6. may manage his/her personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his/her behalf should the facility accept his/her written delegation of this responsibility to the facility for any period of time in conformance with State Law
7. is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself/herself or to others
8. is assured confidential treatment of his/her personal and medical records, and may approve or refuse their release to any individual outside the facility, except in the case of his/her transfer to another health care institution, or as required by law or third-party payment contract
9. is treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs

10. is not required to perform services for the facility that are not included for therapeutic purposes in his/her plan of care

11. may associate and communicate privately with persons of his/her choice and send and receive his/her personal mail unopened, unless medically contraindicated (as documented by his/her physician in his/her medical record)

12. may meet with, and participate in, activities of social, religious and community groups at his/her discretion, unless medically contraindicated (as documented by his/her physician in his/her medical record)

13. may retain and use his/her personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or unless medically contraindicated (as documented by his/her physician in his/her medical record)

14. if married, is assured privacy for visits by his/her spouse, if both are patients in the facility they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in his/her medical record)

15. is fully informed of the availability of all current state, local and federal inspection reports

16. may organize, maintain and participate in a patient-run resident council, as a means of fostering communication among residents and between residents and staff, encouraging resident independence and addressing the basic rights of nursing home patients and clients free from administrative interference or reprisal

17. is entitled to the opinion of two physicians concerning the need for surgery, except in an emergency situation, prior to such surgery being performed.

Received and accepted: ________________________________
(Patient)

____
Authorized representative (give
relationship to patient)

Date ________________________________

for the facility:

________________________________ (Name and Title)

Any facility and agency that negligently deprives a patient of any right or benefit created or established for the well-being of the patient by the provisions of this section shall be liable to such patient in a private cause of action for injuries suffered as a result of such deprivation. Upon finding that a patient has been deprived of such a right or benefit, and that the patient has been injured as a result of such deprivation, damages shall be assessed in the amount sufficient to compensate such patient for such injury. In addition, where the deprivation of any such right or benefit is found to have been willful or in reckless disregard of the rights of the patient, punitive damages may be assessed. A patient may also maintain action pursuant to this section for any other type of relief, including injuctive and declaratory relief, permitted by law, exhaustion of any available administrative remedies shall not be required prior to commencement of suit under this section.

Patient Rights and the above were taken from Public Act No. 79-378.

LESSON PLAN: 4

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-4 OR DEMONSTRATION:

CLIENT RECORDS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Recognize common abbreviations and symbols used in charting.
3. Record observations using basic guidelines.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Flow Sheet
2. Pen
3. Charting paper
4. Blackboard
5. Dictionary

TEACHER RESOURCES:

INTRODUCTION:

There is a need for accurate descriptions of the care given to clients and the conditions that exist throughout a client's period of care. The progress notes must communicate clearly and efficiently with government agencies, health care professionals, and the consumer. We will discuss how to record effective, accurate descriptions of care given and observations made of your assigned client. How much you will need to record depends upon the policy where you are employed.

LESSON PLAN: 4

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Ambulatory - able to walk

B. Catheter - a sterile tube inserted into the bladder to drain urine

II. Abbreviations and Symbols (CD-1)

A. Activities of daily living (ADL)

1. ad lib - as desired
2. amb. - ambulatory
3. B.M. - bowel movement
4. BRP - bathroom privileges
5. BSC - bedside commode
6. cath. - catheter
7. G/C - geri-chair
8. H.O.B. - head of bed
9. R.O. - reality orientation
10. R.O.M. - range of motion
11. SOB - shortness of breath
12. W/C - wheelchair

B. Food and fluids

1. ac - before meals
2. amt. - amount
3. cc - cubic centimeter
4. FF - force fluids
5. H_2O - water

6. I & O - intake and output
7. IV - intravenously
8. Liq. - liquid
9. NPO - nothing by mouth
10. pc - after meals
11. PO - by mouth
12. ss - one half

C. Vital signs

1. VS - vital signs
2. BP - blood pressure
3. ht - height
4. TPR - temperature, pulse, respiration
5. wt - weight

D. Time and frequency

1. a.m. - morning
2. hr - hour
3. hs - hour of sleep; bedtime
4. od - once daily
5. p.m. - afternoon
6. prn - whenever necessary
7. q - every
8. qid - four times a day
9. q4h - every 4 hours
10. tid - three times a day

E. Miscellaneous

1. a - before
2. a&o - alert and oriented

3. B&B - bowel and bladder

4. c - with

5. c/o - complains of

6. O_2 - oxygen

7. p - after

8. s - without

9. S&A - sugar and acetone test

10. Sol - solution

III. Charting

A. Purpose (CD-2)

1. To communicate with other members of the health care team

    a. Physician's orders are written based on the needs of the client

    b. Care plan (needs are identified from the chart

    c. Progress notes

2. To document the delivery of care to meet needs of the client

3. To document and provide evidence to regulatory agencies that care has been provided as ordered and requirements for licensure and certification are met

4. To document for insurance purposes and /or legal actions

B. Charting responsibilities

1. Monthly summary done by licensed or charge personnel

2. Daily care routines (bathing, B&B, turning, etc.) charted by personnel completing task according to facility or agency policy.

C. Basic rules (according to facility or agency policy)

5. Use simple, correct terminology. Use correct grammar, spelling, and punctuation (refer to a dictionary).

6. Use direct quotes when describing an emotional state.

   Example: Mrs. Jones stated, "I am so depressed today."

7. Indicate number of times an event occurs during a shift, day, week, etc.

8. Make follow-up notations of results of actions relative to the care plan.

9. Read notations made by other personnel.

10. Record client's reactions to family and visitors.

11. Never chart a procedure before it has been performed.

12. All charting is done in ink with a ball-point pen. Do not use felt-tipped pens.

13. Always record date and time.

14. Second-hand information which is reported should be recorded as such; that it was told to you by the client's roommate (for example). Do not chart it as your own first-hand observation -- qualify it.

15. Always sign your name with first initial , last name, job title - M. Smith, NA.

D. Variations in charting

1. Check chart (HO 1)

   a. Check the appropriate square

   b. Check the appropriate description of action

2. Narrative notes (Nurse's Progress Record) written out in sentence form; should cover the following information: (HO 1 - reverse)
   a. Mobility and balance

   b. Diet and eating habits

c. Bathing, dressing and grooming

d. Elimination

e. Speech, hearing and sight

f. Behavior and mental condition

g. Restorative nursing procedures

h. Dentition (condition of teeth) and oral hygiene

i Comfort measures

j. Spiritual needs

k Sleeping patterns

l Any other problems identified in plan of care

IV. Summary and Conclusion

A. Terms and definitions

B. Abbreviations and symbols

C. Charting

Accurate documentation of the care given to a client is important to prove that the expected care was given. It should be brief but descriptive. Decisions affecting care can be made on the basis of what is recorded on the chart.

LESSON PLAN: 4

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What are some of the abbreviations you have used or noted? (Write on chalkboard.)

2. What are some reasons why charting is important?

3. Why is it important not to erase charting? Why is it important to chart only in ink?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Prepare flash cards for "Abbreviations Bee."

2. Divide class into two groups for "Abbreviations Bee."

3. Fill out check charting form (HO 1 or facility's form) using information given by the instructor.

LESSON PLAN: 4

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

EVALUATION ITEMS:

1. Define the term ambulatory.

2. Define the term catheter.

3. Which of the following is the correct way for this nurse assistant to sign her name? (Circle the letter of the correct answer.)

   a. Susan Metz
   b. Susan Metz, NA
   c. S. Metz
   d. S. Metz, NA

4. You have made an error in charting on a resident's chart. Which one of the following examples below is the procedure for correcting it? (Circle the letter of the correct answer.)

   a. Draw one line through it.
   b. Mark several lines through it.
   c. Draw one line through it, write the word "error," and place your initials by it.
   d. Erase the error.

Match the following abbreviations and symbols with the correct term by writing the letter in the blank.

______ 5. After meals
______ 6. Ambulatory
______ 7. Before
______ 8. Bowel and bladder
______ 9. Bowel movement
______ 10. Cubic Centimeter
______ 11. Every
______ 12. Every 4 hours
______ 13. Four times a day
______ 14 Hour of sleep, bedtime
______ 15. Oxygen
______ 16. Range of motion
______ 17. Reality orientation
______ 18. Temperature, pulse, respirations
______ 19. Three times a day

a. R.O.M
b. a
c. hs
d. B&B
e. tid
f. O_2
g. q
h. R.O.
i. qid
j. TPR
k. cc
l. amb.
m. B.M.
n. pc
o. q4h

On the line provided, write out what each of the following mean:

20. Wt a breakfast $\bar{s}$ shoes. ______________________________
21. Up in G/C ad lib $\bar{c}$ vest restraint. ______________________________
22. NPO at hs for blood test in a.m. ______________________________
23. Bedrest $\bar{c}$ BRP, H.O.B. up for SOB ______________________________
24. Apply lotion bid prn for itching ______________________________

LESSON PLAN: 4

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. Able to walk
2. A sterile tube inserted into the bladder to drain urine
3. d
4. c
5. n
6. l
7. b
8. d
9. m
10. k
11. g
12. o
13. i
14. c
15. f
16. a
17. h
18. j
19. e
20. Weight before breakfast without shoes
21. Up in geri-chair as desired for posey vest
22. Nothing by mouth at bedtime for blood test in the morning
23. Bedrest with bathroom privileges; head of bed was raised because of shortness of breath
24. Apply lotion twice a day whenever necessary for itching

FLOW SHEET

PATIENT CARE FLOW SHEET

DIET CODE: 0=nothing, ¼=25%, ½=50%, ¾=75%, all=100%

	DATE		
	11-7	7-3	3-11
BATH			
COMPLETE			
PARTIAL			
SELF			
SHOWER			
MOUTH CARE			
BACK CARE			
POSITIONING			
PRONE			
SUPINE			
LEFT SIDE			
RIGHT SIDE			
COUGH			
DEEP BREATHE			
ACTIVITY			
BEDREST			
BRP			
CHAIR			
AMB. c̄ ASSIST.			
AD. LIB.			
COMMODE			
DIET TYPE/ % TAKEN			
(B)			
(L)			
(D)			
FEED			
SELF FED			
OBSERVATIONS *****			
E. HOSE REMOV'D			
E. HOSE REPLACED			
CALF TENDERNESS			
ELECTRIC. EQUIP'T			
SAFETY			
RESTRAINTS			
POSEY			
SIDE RAILS			
TREATMENTS			

SHIFT	SPECIAL NEEDS		SIGNA. and INITIAL
11 to 7			
7 to 3			
3 to 11			

PATIENT CLASSIFICATION:

(1) Self Care
(2) Minimal Care
(3) Intermediate Care
(4) Special Care
(5) Total/Intensive Care

11-7	INT.	7-3	INT.	3-11	INT.

SPECIAL NEEDS

					11 to 7
					7 to 3
					3 to 11

DATE & TIME	NURSE'S PROGRESS RECORD	SIGNATURE AND TITLE

LESSON PLAN: 5

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-5 OR DEMONSTRATION:

COMMUNICATION SKILLS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the term communication.
2. Define the term aphasia.
3. Identify the five elements of communication.
4. Define verbal and nonverbal communication.
5. List six types of nonverbal communication.
6. Identify factors that promote effective communication.
7. Describe the difference between hearing and listening.
8. Identify factors that prevent communication.
9. Identify two conditions that could lead to communication difficulties.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: How to be a good listener
2. Trainex filmstrip PC 294: "Verbal Barriers to Communication"
3. Trainex filmstrip PC 295: "Nonverbal Barriers to Communication"
4. Trainex filmstrip PC 290: "Effective Speakers"
5. Trainex filmstrip PC 293: "Effective Listening"
6. Projector

TEACHER RESOURCES:

INTRODUCTION:

One of the most important responsibilities and functions of the nurse assistant is to communicate well with clients, families of clients, visitors and co-workers. This is not always easy. Communication is simply an exchange of information which involves a sender (speaker) and a receiver (listener). To be effective the message must be understood by both parties involved. Communication is a means by which you and your clients reach each other. You must allow the client to talk to you and listen very carefully to what he/she is saying. There are two types of communication: verbal and nonverbal. We will discuss these, as well as how to become more effective as a communicator.

LESSON PLAN: 5

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Communication - the exchange of information accomplished by sending and receiving messages

   B. Aphasia - inability to speak or write or understand the spoken word due to injury or disease of certain brain cells

II. The Five Elements of Communication

   A. Sender (speaker)

      1. Source of information

      2. May be a person or an inanimate object like a TV or radio

   B. Message - the information which is to be sent

   C. Channel of transmission

      1. If the message is spoken, it travels by sound waves to the listener.

      2. If the message is written or gestured, it requires light to see it.

   D. Receiver (listener) - someone or something "hears" the message

   E. Response/Feedback

      1. A person tries to understand and respond to the message.

      2. If the receiver is a machine, its response may be a click.

III. Verbal Communication (CD-1)

A. Definition - getting a message across through the use of words by speaking or writing them.

B. Types of verbal communication

1. Greeting clients and visitors

2. Delivering and receiving messages

3. Carrying on conversations

4. Answering telephones

IV. Nonverbal Communication (CD-2)

A. Definition: getting a message across without the use of words; expressing feelings or emotions in other ways

B. Types of nonverbal communication

1. Facial expressions - smile; frown; twist of the mouth; raised eyebrows

2. Gestures and body movements - a shrug of the shoulders; hand movements

3. Posture of the body - hunching over; standing straight

4. Tone of voice - sarcastic; friendly; firm

5. Smells - the odor of stool, fragrance of cologne

6. Space - the distance between two people as they talk; how close a nurse assistant gets to the client

7. Silence - approving; sympathetic; hostile

8. Touch - gentle; rough; firm

IV. How to Communicate Effectively (CD-3)

A. Introduce yourself frequently.

B. Show an interest in talking with the client.

C. Allow time for talking.

D. Pace yourself to the speed at which the client talks.

E. Try to get at the client's eye level and stay within sight.

F. Remember, when you communicate you are not only conveying words but also your attitudes and feelings about yourself and others.

G. If communication is not taking place, explore the reasons why.

H. Reminiscence is a form of communication for the elderly.

   1. A way of reviewing life; helps in a search for meaning and to prepare for death

   2. Listen to his/her stories--this allows the client to feel he/she is leaving wisdom or insight to the young.

VI. How Hearing and Listening Differ

A. Hearing is a passive awareness of sound.

B. Listening is an active, intentional effort to hear the message and understand its meaning.

C. Nursing action (HO 1)

   1. Requires concentration and close attention to what is being said and done.

   2. Have direct eye contact with the person who is speaking.

   3. Be alert when listening.

   4. Try to put aside your own prejudices and values.

VII. Barriers that Prevent Communication (CD-4)

A. Changing the subject

B. Giving your own opinion about the person and his/her situation without being asked

C. Belittling a person's feelings

D. Seeming to be too busy

E. Jumping to conclusions before you know the entire story

F. Giving false or inappropriate reassurances

G. Causing fear of an unpleasant response

H. Interrupting frequently

I. Not waiting long enough for a reply (elderly slower to respond)

J. Words that sound alike (homonyms) may have a different meaning to the receiver than was intended by the sender

a. a "plane" is a flying vehicle

b. a "plain" is a wide, open field

K. Meanings of words sometimes change from one generation to another

VIII. Clients with Communication Difficulties

A. Deafness

1. Signs indicating hearing loss

a. Loss of interest in group activity, in other persons, or in what is beig said to him/her

b. Apparent disregard for directions or suggestions

c. An attempt to lip-read

2. Encourage the client to use a hearing aid and give him/her time to adjust it.

3. Face the client in a lighted area; stand where he/she can see you.

4. Use moderate tone of voice; do not shout at the client.

5. Reduce background noise.

6. Attempt to learn some sign language.

B. Blindness

1. Observe for signs indicating deteriorating eyesight.

a. Stumbling or falling; holding on to objects when walking

b. Using touch to find personal things

2. Encourage use of eyeglasses.

3. Use verbal communication if client can hear; use normal tone of voice.

4. Use touch.

5. Identify self when entering or leaving a room.

6. Keep surroundings the same--do not rearrange personal items or furniture without informing client.

C. Speech disorders

1. Dysarthria - weakness or paralysis of muscles of lips, toungue, and throat; may be due to brain damage from stroke or accident

2. Apshasia - language disorder in which resident has difficulty understanding words and using them correctly due to damage of the part of the brain that controls speech

    a. Expressive - client has difficulty saying what he/she is thinking and wants to say; may also have trouble writing and making gestures to act out what he/she is trying to say

    b. Receptive - client can't understand what is being said to him/her; gestures and pantomime may confuse him/her; may have difficuly understanding what he/she is reading or recognizing the words

3. How to communicate to client with speech disorder:

    a. Encourage client to express self in any way possible.

    b. Continue to talk to the client and encourage others to also.

    c. Use short, simple sentences and use the same words each time when you give directions.

    d. Watch the client for gestures or body movements with which he/she may be communicating.

    e. Be patient, do not speak for the client, although you may want to help him/her with which words he/she is having difficulty.

    f. Do not talk with another person in front of the client as if he/she cannot understand.

    g. Remember the client is still considered an adult.

    h. Remember the basic principles of effective communication.

IX. Summary and Conclusion

A. Terms and definitions

B. The five elements of communication

C. Verbal communication

D. Nonverbal communication

E. How to communicate effectively

F. How hearing and listening differ

G. Barriers that prevent communication

H. Residents with communication difficulties

Remember, in order to be of help, you must learn to communicate with your clients. If at any time you have difficulty, try to determine the cause of the lack of communication. Review the information in this lesson often to keep yourself aware of the basic principles. Your effective communication skills are invaluable to both you and others.

LESSON PLAN: 5

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What do you think the difference is between verbal and nonverbal communication?
2. What are some of the ways you communicate without ever saying a word?
3. Can you give an example of a way to promote communication with a depressed client?
4. Can you give an example of an event that would prevent communication with a client?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Show filmstrips.
2. Have class members choose a partner; then have them talk nose to nose, then 15 inches away from one another, and then back to back. This exercise helps them to understand concept of "personal space." Discuss how they felt when talking from various distances.

LESSON PLAN: 5

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

EVALUATION ITEMS:

1. Define the term communication.

2. Define the term aphasia.

3. What is the difference between verbal and nonverbal communication?

4. List four examples of nonverbal communication.

   a.

   b.

   c.

   d.

For each of the following, write "T" if the statement is true or "F" if it is false.

______ 5. There must be a sender and a receiver for communication to take place.

______ 6. Reminiscence is not a form of communication.

______ 7. Listening is a passive awareness of sound.

______ 8. An apparent disregard for directions or suggestions may be a sign of deafness.

______ 9. A person with a speech problem may know what he or she wants to say but is unable to say it

______10. It is important to use the nonverbal communication techniques of touching when communicating with the blind resident.

______11. Always look directly at the client who is speaking to you.

On the line provided write 1 if the statement is a barrier to communication or a 2 if it is an effective way to communicate.

______12. Belittling a person's feelings

______13. Changing the subject

______14. Showing an interest in discussion

______15. Seeming to be too busy

______16. Listening

______17. Staying within sight of the client at eye level

______18. Pacing yourself to the speed at which the client talks

LESSON PLAN: 5

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. Communication is the exchange of information accomplished by sending and receiving messages.

2. Aphasia is the inability to speak or write or understand the spoken word due to injury or disease of certain brain cells.

3. Verbal communication is the act of sending a message through the use of words by speaking and writing them, and nonverbal communication gets the message across without the use of words by expressing feelings or emotions in other ways.

4. The student may list any four or the following:

   a. Facial expressions
   b. Gestures and body movements
   c. Posture of the body
   d. Tone of voice
   e. Smells
   f. Space
   g Silence
   h. Touch

5. T
6. T
7. F
8. T
9 T
10. T
11. T
12. 1
13. 1
14. 2
15. 1
16. 2
17. 2
18. 2

HOW TO BE A GOOD LISTENER

1. STOP TALKING!
   You cannot listen if you are talking.

2. PUT THE SPEAKER AT EASE.
   Help the speaker feel free to talk. Provide what is often called a "permissive environment."

3. SHOW THE SPEAKER THAT YOU WANT TO LISTEN.
   Look and act interested. Do not read your mail while someone is talking. Listen to understand rather than to reply.

4. REMOVE DISTRACTIONS.
   Don't doodle, tap, or shuffle papers. Shut the door if it will be quieter.

5. EMPATHIZE WITH THE SPEAKER.
   Try to put yourself in the speaker's place so that you can see that point of view.

6. BE PATIENT.
   Allow plenty of time. Do not interrupt. Do not start for the door or walk away.

7. HOLD YOUR TEMPER.
   An angry person gets the wrong meaning from words.

8. GO EASY ON ARGUMENT AND CRITICISM.
   Do not put the speaker on the defensive. The speaker may "clam up" or get angry. Try not to argue; even if you win, you lose!

9. ASK QUESTIONS.
   Encourage the speaker and show you are listening. Questions also help to develop further points.

10. STOP TALKING!
    This is first and last, because all other listening skills depend upon it. You just can't do a good listening job while you are talking!

Nature gave people two ears but only one tongue, which is a gentle hint that listening is more important than talking!

Major benefits of good listening are:

- A good listener can make better decisions.
- A good listener saves time.
- Listening helps the speaker determine how well the message is being received.
- A good listener stimulates others to better speaking.
- Good listening decreases misunderstanding.

LESSON PLAN: 6

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-6 OR DEMONSTRATION:

OBSERVATION AND REPORTING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List five methods of observation.
3. Recognize changes in client's usual appearance and behavior.
4. Match medical terms to correct definitions.
5. Use guidelines for reporting observations of status change in clients to charge personnel.
6. Define the term grievance.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #405: "Observation and Charting"
2. Projector
3. Color-coded flash cards for terms and definitions - Teacher made

TEACHER RESOURCES:

INTRODUCTION:

Making useful observations gives the nurse assistant satisfaction and a feeling of achievement but more important than that, it can provide nurses and physicians with important information for proper care of the client. Observation techniques must be practiced each day and require the use of all of one's senses. Get in the habit of observing your client anytime you are with him/her. Check your client from head to toe each day. It is a good idea to carry a pad and pen in your pocket to record observations so you will not forget to report and document them.

LESSON PLAN: 6

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

A. Anterior - toward the front

B. Abrasion - a scraping or rubbing off of the skin

C. Constipation - difficult or infrequent movement of the bowels

D. Constrict - get smaller

E. Cyanotic - a bluish-gray color of the skin, lips, or nail beds due to lack of oxygen

F. Dilate - to get larger

G. Disorientation - state of mental confusion or loss of bearings (sense of time, place, or identity)

H. Distention - state of being inflated, enlarged, or stretched out

I. Dysphagia - difficulty swallowing

J. Dyspnea - difficulty in breathing

K. Edema - swelling due to an accumulation of watery fluid in the tissue

L. Emesis - vomiting

M. Feces - waste product of digested food discharged from the intestine (stool, BM)

N. Flatus - gas in intestines

O. Flushed - reddened color of the skin

P. Incontinent - inability to control evacuation of one's bowels, or bladder, or both

Q. Inflammation - reaction of tissue to injury of any kind

R. Jaundice - yellow discoloration of skin due to excess bile in blood

S. Laceration - wound produced by cutting or tearing

T. Mucus - sticky substance secreted by mucous membranes mainly in the lungs, nose, and parts of the rectal and genital areas

U. Pallor - paleness

V. Posterior - towards the back

W. Projectile - vomiting, forcibly ejected without nausea

X. Pus - thick yellow/green secretion formed in certain kinds of inflammation

Y. Void - to pass urine

II. Observation - you have used these skills all of your life but may have never realized it

A. Five methods of observation (CD-1)

1. Seeing

a. Look and think about what you are seeing and what it means.

b. Observe for skin rash, reddened areas, edema, etc.

2. Hearing

a. Listen to a sound and try to understand it means

b. Listen to a cough or wheezing sound when the client breathes.

c. Some changes can be felt and described only by the client - pain, nausea, dizziness, a ringing in the ears, or headache. Listen for verbal signs from the client.

3. Smelling - smell the odor of a discharge or the client's breath

4. Touching

a. You can feel signs with your fingers.

b. You may note if the skin is hot or cold, wet or dry, or changes in the pulse rate.

5. Vital signs - a change can indicate many things; anything not within normal range may be significant and should be reported.

B. Things to observe (CD-2)

1. Activities of daily living (A.D.L.) (independent/ dependent)

   a. Dressing - untidy, unclean, or neat, clean

   b. Grooming - disheveled or neat

   c. Walking

      1) Gait steady or unsteady; shuffling
      2) Difficulty getting up and out of bed

   d. Eating and drinking

      1) Good appetite or no appetite

      2) Dislikes diet or tries some of each food

      3) Amount eaten or type and amount not eaten

      4) Dysphagia or difficulty swallowing

      5) Thirsty or seldom drinks water

   e. Elimination

      1) How often does client void?

      2) Note color, odor, amount and clarity (clearness) of urine.

      3) Is voiding hard to start or is there pain during urination?

      4) Incontinent of urine?

      5) Catheter--is it in place and draining properly
      6) How often does client have a BM?

      7) Note color, odor, amount and consistency (liquid, loose, hard) of stool.

      8) Note blood, clumps of mucus, clay color, or if feces looks like black tar.

   f. Sleeping

      1) Able to sleep or restless

      2) Sleeps more than normal, constantly asleep

      3) Lies still or tosses around

        4) Complains about not being able to sleep (compare with your observation)

2. Mental condition or mood (CD-3)

    a. Level of orientation--who, what, where

    b. Talkative or not talkative

    c. Talking sensibly or not making sense

    d. Anxious and worried, or very calm

    e. Speaking rapidly or slowly

    f. Cooperative or not cooperating

    g. Client is irritable, depressed, hostile, combative

    h. Delirium

        1) Continuous or intermittent; rambling of ideas or one persistent idea

        2) Coma or unconscious, failure to respond to verbal commands or stimuli

    i. Crying - fretful, sharp, whining, or moaning; give reason if known

3. Position

    a. Time of position change; what position client is put in

    b. Able to move easily or requires assistance of two or three staff members

4. Skin

    a. Color - pallor, flushed, cyanotic, jaundiced

    b. Dry or moist

    c. Warm (hot) or cool (cold)

    d. Edema - location, general or local, any color changes

    e. Reddened areas - location, open, size, drainage

    f. Rash, hives, itching, bruises, abrasions, lacerations

5. Eyes, ears, nose, and mouth
    a. Eyelids inflamed; watery eyes; bloodshot appearance or yellowish cast to the whites of the eyes, swollen eyelids
    b. Bothered by bright light; twitching
    c. Pupils - constricted or dilated; unequal or equal in size
    d. Eyes appear to be fixed; constant involuntary movement, especially side to side
    e. Ability to hear you
    f. Difficulty breathing through his/her nose
    g. Mucus discharge from the nose
    h. Mouth - lost or broken dentures, sores, tenderness, bleeding gums
    i. Complaint of a bad taste in mouth; odor of breath - foul (halitosis), sweet or fruity, alcohol
6. Breathing
    a. Noises when he/she breathes; wheezing; moist sounding
    b. Dyspnea; difficulty breathing, relieved by standing or sitting erect or by squatting.
    c. Cough - productive (note amount, color, and consistency of sputum) or dry; tight hacking, painful
7. Abdomen
    a. distended, hard; rigid; tender
    b. Gassiness; belching; hiccoughs
    c. Nausea
    d. Emesis (vomiting) - self-induced; projectile; note color, consistency, and amount
8. Movements
    a. Shaking - tremor
    b. Jerky - spasm
    c. Limp

9. Pain

   a. Location

   b. Duration (How long has he/she had pain?)

   c. Description of pain - constant, comes and goes, sharp, dull; arching, knifelike

   d. If client has taken pain medication; if the medication relieved the pain

10. Vital signs

   a. Temperature - febrile or afebrile (fever or normal)

   b. Pulse - rhythm--regular or irregular; rate--too fast or too slow; force--strong or weak

   c. Respiration

      1) Rhythm--regular or irregular; rate--too fast or too slow; shallow

      2) Cheyne-Stokes - uneven rhythm and rate, and periods of no breathing

   d. Blood pressure - strong (easy to hear) or weak (difficult to hear), measurement

11. Other

   a. Convulsions - time, duration, intermittent or continuous; mild or violent; generalized or limited to one part of the body

   b. Chills - time and duration, severity of chill; temperature at time chill is completed, temperature 30 minutes after chill is completed

   c. Accidents or incidents - time, witnesses, observations of injury, and cause of suspected injury

   d. Discharges - unusual body discharge; location and type (bloody, mucus, pus, or clear)

III. Guidelines for Reporting Observation of Status Change

A. Observe for the unusual, then report only what you observe. Be objective, do not make judgements or try to diagnose.

B. Note any time, the name of the client, location of any abnormal signs, location of client in facility or home, any symptoms the client verbalizes, and report to the charge nurse as soon as possible.

IV. Summary and Conclusion

A. Terms and definitions

B. Observation

C. Guidelines for reporting observations of status change

Making observations is one of the most important functions of your job as a nurse assistant. Always be alert for changes and abnormalities of the condition of each of your clients. Become familiar with the terminology that has been included in this lesson.

LESSON PLAN: ___6___

COURSE TITLE: NURSE ASSISTANT

UNIT ___I___: THE NURSE SSISTANT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_______ 1. Abrasion

_______ 2. Anterior

_______ 3. Constipation

_______ 4. Constrict

_______ 5. Cyanotic

_______ 6. Dilate

_______ 7. Disorientation

_______ 8. Distention

_______ 9. Dyspnea

_______10. Dysphagia

_______11. Edema

_______12. Emesis

_______13. Feces

_______14. Flatus

_______15. Flushed

_______16. Incontinent

_______17. Inflammation

_______18. Jaundice

_______19. Laceration

_______20. Mucus

_______21. Posterior

_______22. Pallor

a. To pass urine

b. Difficulty swallowing

c. Yellow discoloration of skin

d. Get smaller

e. Difficulty in breathing

f. Wound produced by cutting or tearing

g. Sticky substance secreted by mucous membranes, mainly in the lungs, nose and parts of the rectal and genital areas

h. Toward the back

i. Gas

j. A bluish-gray color of the lips, skin,or nail beds

k. Toward the front

l. Scraping or rubbing off of skin

m. State of mental confusion or loss of bearing (sense of time, place, or identity)

n. Reddened color of the skin

o. Thick, yellowish, greenish secretion formed in certain kinds of inflammation

p. Waste products of digested food discharged from the intestine

_______23. Projectile

_______24. Pus

_______25. Void

q. To get larger

r. Reaction of tissue to injury of any kind

s. Vomiting forcibly ejected without nausea

t. Swelling due to accumulation of watery fliud in the tissue

u. Inability to control evacuation of one's bowels, or bladder, or both

v. State of being inflated, enlarged, or stretched out

w. Difficult or infrequent movement of the bowels

x. Paleness

y. Vomiting

26. List the five methods of observation.

a.

b.

c.

d.

e.

27. Mrs. Smith yells at you as you enter her home, "Hurry up and get me dressed. What's wrong with you? Can't you see I need help?" The tone of her voice is sharp and impatient. As you are assisting Mrs. Smith to the w/c you note a sweet, fruity odor on her breath, she has a skin tear that is oozing blood on her right forearm and her face is flushed and very warm. What observations can you make?

What is your next step?

28. You are in the dining room at noon. Mrs. Mabel Smith, a client, is sitting next to the client you are feeding. She keeps repeating "I'm so sick", she appears pale--all of a sudden she grabs her chest and starts crying out with pain. The L.P.N. comes over and starts to check her vital signs. She asks you to get the Charge Nurse. What will you tell the Charge Nurse?

LESSON PLAN: 6

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. l
2. k
3. w
4. d
5. j
6. q
7. m
8. v
9. e
10. b
11. t
12. y
13. p
14. i
15. n
16. u
17. r
18. c
19. f
20. g
21. h
22. x
23. s
24. o
25. a

26. a. Seeing
    b. Hearing
    c. Smelling
    d. Touching
    e. Vital sings

27. The nurse assistant should not the following observations: 1. The tone of the client's voice; 2. Sweet, fruity odor on her breath; 3. Skin tear that is oozing blood--right forearm; 4. Flushed and warm face. Report all of these things immediately by phone to the H.H.C.A. supervisor.

28. The N.A. will say "Mrs. Mabel Smith is sitting in the dining room. She is pale and stated "I'm so sick." She grabbed at her chest and started crying out loud. The L.P.N. is checking her vital signs."

LESSON PLAN: 7

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

SCOPE OF UNIT:

This unit is about the role of the nurse assistant (NA) in long-term care and home health care agencies. More specifically, we will discuss the requirements for becoming a nurse assistant--general information, as well as factors that can help the NA become successful; how the NA fits into the structure of the health care team; ethical and legal responsibilities of the NA; how to accurately chart on the medical record; how to effectively communicate; how to make accurate observations about the clients and what to do with the information; and how to use a care plan.

INFORMATION TOPIC: I-7 OR DEMONSTRATION:

USING THE PLAN OF CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify how a care plan is developed.
3. Identify how the care plan is put to use.
4. Identify who is responsible for evaluating the care plan.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Overall Plan of Care
2. HO 2: H.H.C. Plan

INTRODUCTION:

A plan of care is a written plan that is the basis for all care given to a client. It identifies needs and states goals for the client to strive for within a certain time frame. Some are short-term, indicating the need for the client to realistically accomplish this within a short time span--such as a few weeks. There are long-term goals which cover a period of months. The care plan indicates the way or by what action these goals will be accomplished and who the responsible team members are for each particular need. It is the basic tool for the daily nursing care a client will receive.

It is extremely important for the nurse assistant to use the observation and reporting skills she or he has learned to contribute vital information to the care plan. You will not be required to write care plans, -- this is a registered nurse's responsibility -- but you will need to contribute information daily to this process.

LESSON PLAN: 7

COURSE TITLE: NURSE ASSISTANT

UNIT I: THE NURSE ASSISTANT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Assessment - the act of collecting as much information as possible.

   B. Goal - the desired end result, what one hopes to accomplish

   C. Implementation - carrying out a plan of action

   D. Need - something essential or desirable that one is lacking or something one feels is lacking

   E. Problem - needs that a client cannot meet by himself/herself

   F. Client care plan - an individual plan of nursing care for each client

II. Development of the Plan of Care

   A. Assessment of needs of client (CD-1)

      1. Interview client and family members

      2. Observations made by staff (health care team members)

      3. Examination of client by registered nurse

   B. Health care team coordinates planning (CD-2)

      1. Identify problems or needs (CD-3)

      2. Establish goals. Involve client in this process.

      3. Choose approaches or methods.

      4. Identify service (team members) responsible to assist client with need or problem.

   C. Care plan forms vary from facility to facility and agency.

III. Implementation of the Plan of Care

A. Staff (including nurse assistant) refers to care plan for direction.

B. Staff motivates client to goals.

C. Charting reflects progress or regression.

D. Is a reference for reporting changes.

E. Is a reference for physician, administrator, and licensed nurses, therapists, activities director, social services designee, and dietician

IV. Evaluation of Plan of Care

A. Done by the charge nurse

B. Each care plan reviewed and revised at least quarterly and when the condition of the client changes

C. Identify new problems

V. Summary and Conclusion

A. Terms and definitions

B. Development of the plan of care

C. Implemenation of the plan of care

D. Evaluation of the plan of care

Now that you are aware of what a care plan is and how it is developed and used, you will be able to use it as a guide to your daily duties.

LESSON PLAN: 7

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. How does the health care team find out what the client's needs are?
2. Can you think of some needs or problems a client may have?
3. Who contributes information to the care plan?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Read a plan of care (HO 1 and 2); what did it tell you about the client that you did not know?
2. How will you use what you just learned about this client as you care for him/her?

LESSON PLAN: 7

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_______ 1. Assessment

_______ 2. Client care Plan

_______ 3. Goal

_______ 4. Implementation

_______ 5. Need

_______ 6. Problem

a. Something essential or desirable that one is lacking or something one feels is lacking

b. Carrying out a plan of action

c. The act of collecting as much information as possible

d. Need that a client cannot meet by himself/herself

e. An individual plan of nursing care for each client

f. The desired end result; what one hopes to accomplish

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 7. All clients with similar care needs are grouped together in one plan of care.

_______ 8. Only a registered nurse can contribute information to the care plan.

_______ 9. The plan of care contains problems, goals and approaches.

_______10. It is only necessary to update the plan of care when preparing for a state inspection.

_______11. Only the registered nurses and licensed practical nurses are allowed to look at the plan of care.

_______12. The nurse assistant can provide information for the plan of care through the charge nurse.

LESSON PLAN: 7

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. c
2. e
3. f
4. b
5. a
6. d
7. F
8. F
9. T
10. F
11. F
12. T

OVERALL PLAN OF CARE

Personal Care:

BATH
Bathe M.W. Sat.
Partial P.r.n.
Self
Tub
Shower
Assist

MOUTH CARE
Nurse ✓
Self
Dentures ✓
Special

HAIR CARE
Shampoo bed
When 1/11
Nurse ✓
Self
Beauty Shop

SKIN CARE
Decubiti
Turning q̄ 2h
6-8-10-2-4
Dry
Shave
When

HAND/FOOT CARE
Manicure 1/12
Pedicure 1/12
Clean Nails Daily ✓
Self
Footboard ✓

(chair scale)
Weight q̄ tues.
Height
T.P.R. daily
B.P. daily
I & O to 2500 c.c.
C & A

Long Term Goal: To be independent in A.D.L. by July 15

Date	Needs: Problems or Strengths	Short Term Goals	Plan of Action	Service Responsible	Review Date and Signature	Goal Met YES	Goal Met NO	Analysis: Why Goal Not Made
1/12	Totally dependent in A.D.L.	will turn self in bed unaided by 2/10	Reposition q̄ 2h	Nursing				
			Teach how to assist	P.T.				
			R.O.M. x 10 t.i.d.					
		Will assist in feeding self by 1/24	Position sitting in chair for meals	Nursing Dietary				
			Provide adaptive aids Teach to use	O.T.				
	Incontinent — admitted with catheter.	Will remove catheter by 1/17	Push fluids 2500 c.c. daily Clamp catheter 55 min. of every hour.					

Diagnosis: C.V.A. / Rt. hemiplegia

Next of Kin: John J. Doe 314-654-2310

Name: Doe, Mrs. Martha Jane
Doctor: Ari Stotle
Room: 101
Age: 73
Religion: Protestant
Admission Date: 1/10

Special Procedures:

Foley Catheter
clamp 55 min., $\bar{q}$ hour
open drainage 9pm-7a.m.
no irrigation unless problems with drainage.

Medications:

Inderol 40 mg. q.i.d.
Librium 5 mg. b.i.d.
Lasix 40 mg. $\bar{q}$.d, p.r.n. for edema
Colace capt h.s., p.r.n. for constipation
Pyridium tabt t.i.d. x 14 days

Prosthesis:
Dentures: ✓
Full ✓
Partial
Upper
Lower
Glasses: ✓
Contacts:
Hearing Aid:
Artificial Arm:
Leg:
Eye:
Other:

P.T.
R.O.M. x 10 all extremities t.i.d. (by P.T. o.d., Nurse Assistant b.i.d. in room.)

O.T.
Teach to use adaptive eating utensil in G-chair located in Special Dining Room.

Speech/Audiology:
Therapy 3x week (Mon., Wed., Fri., @ 10:30 a.m.)
To Speech Therapist's office via w/c

Diet: 2 Gm Sodium Restricted
Feed: ✓
Assist:

Self-Help Devices: Weighted spoon with extended handle.

Breakfast	Med A.M.	Dinner	Med P.M.	Supper	H.S.

Dislikes/Allergies: Salads
Milk

Activities:
Group:

Individual: Activities Director - read letter and hometown newspaper, provide environmental stimulation.

HOME HEALTH CARE PLAN

HO 2

Home Health Aide Record of Activities

Patient ______________________ Primary Care Nurse ______________________

Address ______________________ Week Ending Date ______________________

	M	T	W	T	F	S	S
Day							
Date							
Hours in Home							
Activity (Check appropriate items below)							
PERSONAL CARE							
Bath--bed, shower, tub, Complete/partial sponge							
Mouth Care							
Foot Care--wash/soak							
Hair Care--shampoo/ comb and brush							
Nail Care							
Shave--electric razor only							
Assist in dressing/encourage to dress self							
Other							
THERAPEUTIC MEASURES							
Assist with self-administered medications							
Record temperature, pulse, respiration							
Care to pressure areas--skin, back care--specify							
Weigh/record							
Prescribed exercises taught by RN/RPT/ST/OT							
Measurement/record							
ELIMINATION							
Assist to bathroom, commode, bedpan, urinal							
Urine--test/record							
Measure urine output/record							
Check bowels and bladder							
EMOTIONAL-BEHAVIORAL							
Encourage conversation							
Encourage activity							

	M	T	W	T	F	S
MOBILITY						
Bedrest/up as tolerated						
Change position						
Transfer bed/chair/lift						
Assist with ambulation						
Take outdoors						
Use of appliances/wheelchair, walker, crutches, cane, leg brace, other (specify)						
FOOD SERVICE						
Diet--regular/special (specify)						
Nutrients (specify)						
Fluids--force/restrict (specify amounts						
Measure intake/record						
Prepare meals--meal planning						
Grocery shopping/other errands						
Encourage food						
Feed patient						
HOMEMAKING						
Make/change bed linens						
General Homemaking						
Kitchen/bathroom						
Laundry/ironing						
Dust/floor care						
Vacuuming, dry mop, wet mop						

Other/Special Precautions to be Observed

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Signature of HHA ______________________ Date ______________________

Signature of HHA Supervisor ______________________ Signature of Primary Care Nurse ______________________

LESSON PLAN: 8

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

SCOPE OF UNIT:

This unit covers the client's home environment including the family, types of families, changing roles of family members, types of housing, utilities and finances, care of the home environment, pest control and community resources. This unit also covers the long-term care environment.

INFORMATION TOPIC: II-8

THE FAMILY, FAMILY RELATIONSHIPS, HOUSING, UTILITIES, FINANCES

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify four family types.
2. Describe advantages and disadvantages of one family type.
3. Identify changes in social relationships that children, adults and the disabled may experience..
4. Discuss housing alternatives for the disabled and for the elderly.
5. Identify two sources for housing and financial aid available through private and government agencies.
6. Identify community resources available to improve the quality of life of the client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

H.O. 1	The Extended Family
H.O. 2	The Nuclear Family
H.O. 3	The Single-Parent Family
H.O. 4	The Communal Family
H.O. 5	The Blended Family

Film - Money Tree - State of Connecticut Home Economics Film Library

16 mm Projector and screen

TEACHER RESOURCES:

INTRODUCTION;

The family is an important unit of our society. It is the place where needs for affection, acceptance, security, trust and socialization are first met. Families are bound together by blood ties, common interests, loyalties and affection. It is important to maintain the stability of the family even when it becomes disrupted by illness, financial difficulties, marital problems, disability, substance abuse and addiction and death. The nurse assistant, as a member of the Home Health Care Team, can provide a valuable service using his/her knowledge of housing and resources available to help maintain or improve the client's quality of life.

LESSON PLAN: 8

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

OUTLINE: (Key Points)

I The Family - people living under one roof (CD-1)

A. Family types

1. - Nuclear - immediate family

2. - Step/blended - family a result of a remarriage

3. - Extended - family members include those from an older generation

4. - "Empty nest" - grown children have moved out and parents are once again living as a couple (or single as a result of death or divorce of spouse)

5. - Widowed - death of spouse

6. - Single parent - unmarried, divorced or widowed with children

7. - Other - nontraditional such as a pair - same sex, both sexes; communes - a group sharing use of property

II Family Relationships (CD-3)

A. Roles of family members in relation to family structure or type.
(Example: Head of Household)

B. Family stability
(Example: emotional, financial)

C. Positive coping with a family crisis
(Example: death, abuse, sickness)

D. Lines of communication
(Example: verbal)

E. Displays of love and affection
(Example: verbal, physical)

F. Transcultural
   Example: Your client can be from one of many different countries; Europe, Asia, Africa and Near East, India, South and Central America as well as different parts of the U.S.A. and Canada. He/she may have different value systems and traditions as well as a different culture from what the nurse assistant knows. Language, behaviors and family systems may be different. The nurse assistant must respect these differences, be non-judgemental and perhaps learn about other ways of living while he/she is caring for the client from another culture.

III Housing for the Family - The Home (CD 2)

A. Self-sufficient apartment/house/condominium

B. Developments for handicapped/elderly clients

C. Room or apartment in family member's home

D. Life care apartment with health care facility

E. Commune

F. Single room occupancy in hotel or motel (S.R.O.)

G. Intermediate care facility (I.C.F.)

H. Group home

I. Skilled nursing facility (S.N.F.)

J. Other

IV Utilities - Sources and Services

A. Electric - Power
   (Example: Northeast Utilities, United Illuminating, other)

B. Telephone - communication
   (Example: Southern New England Telephone Co.)

C. Heat and Cooking - comfort and nourishment

   1. Gas
      (Example: Connecticut Natural Gas)

   2. Oil
      (Example: see yellow pages of telephone book)

   3 Electricity - see above

V Finances - (CD-4)

A. Sources of income

1. Pension - private, national, state or local government, railroad
2. Social Security
3. Savings, annuities and insurance
4. Part-time employment
5. Veteran benefits
6. Disability benefits
7. State and local government agencies involved with financial assistance.
   (Example: food stamps, Title XIX (Welfare)
8. Other
   (Example: family member)

VI Summary and Conclusion

A. The family setting

B. Family relationships

C. Housing for the family

D. Forms of utilities

E. Finances

As a nurse assistant you will encounter a variety of families. Each will be unique in its character, relationships and needs. The client and his/her family will often require your knowledge of available resources and where they may turn to for assistance.

LESSON PLAN: 8

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

CLASSROOM DISCUSSION:

1. Discuss the different family groups.
2. What forms of housing are available for the elderly and disabled in the community?
3. How may the role of a family member change when another member becomes ill or disabled?
4. What help is available if a client has difficulty paying electric bills?

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Guest speaker from a utility company to describe special services the company offers to the elderly, disabled or financially disabled person or family.
2. Role play a family crisis (Example: Head of household is hospitalized).
3. Guest speaker from human resources agencies and local housing authorities

LESSON PLAN: 8

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true or "F" if it is false.

_______ 1. A blended family is sometimes created when a remarriage occurs.

_______ 2. A family where children, parents and grandparents live under the same roof is referred to as a nuclear family.

_______ 3. The death of a spouse can cause the roles of family members to change.

_______ 4. Most elderly people live in a skilled nursing facility.

_______ 5. Utility companies do not offer assistance to their customers in financial need.

List 3 sources of financial assistance available to a client.

6.

7.

8.

Name 3 housing alternatives available to the elderly.

9.

10.

11.

LESSON PLAN: 8

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

ANSWERS TO EVALUATION ITEMS:

True/False

1. T
2. F
3. T
4. F
5. F
6. Utility company
7. Local housing authority
8. Veteran benefits
9. Apartment
10. Living with family member
11. Elderly housing development

    A room in family's home

    S.R.O.

    I.C.F.

    S.N.F.

    Group home

    Commune

    Life care apartment

any of these may be listed

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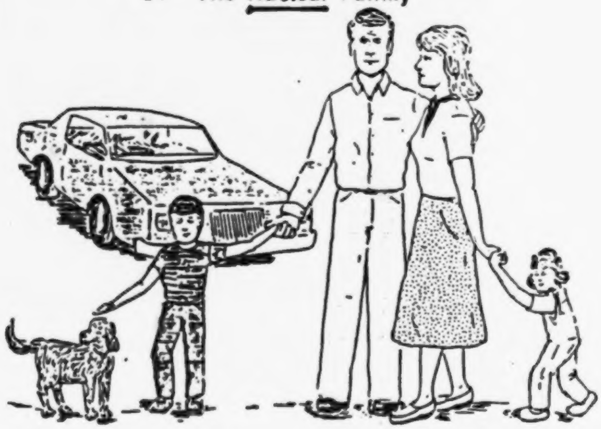
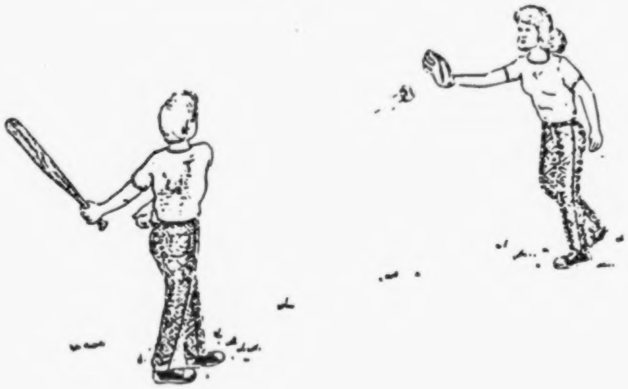
TYPES OF FAMILIES

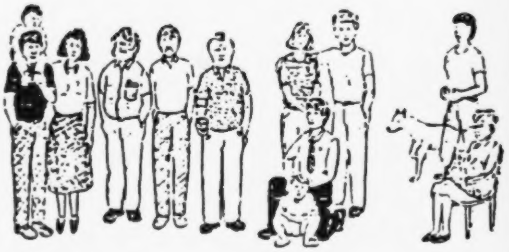
1. **The Nuclear Family**



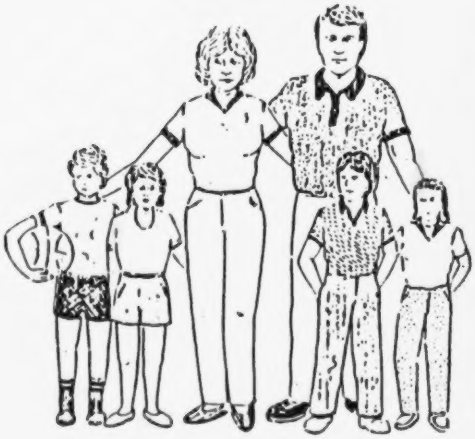
2. **The Single-Parent Family**



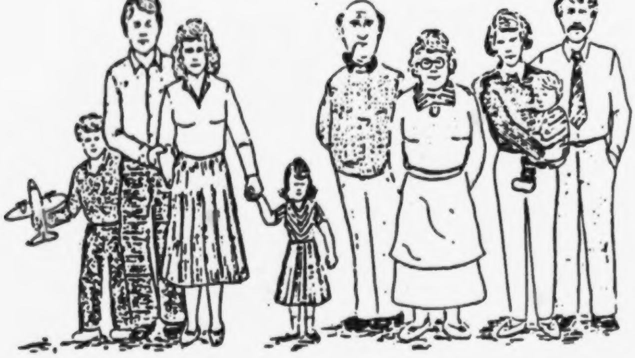
3. **The Communal Family**



4. **The Blended Family**



5. **The Extended Family**



LESSON PLAN: 9

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

SCOPE OF UNIT:

This unit covers the client's home environment including the family, types of families, changing roles of family members, types of housing, utilities and finances, care of the home environment, pest control and community resources. This unit also covers the long-term care environment.

INFORMATION TOPIC: II-9 OR DEMONSTRATION

COMMUNITY RESOURCES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify community resources agencies available for client use.
2. Discuss advantages of utilizing the services of selected community resources.
3. Discuss methods/ways selected community resources may help improve the client's quality of life.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. H.O. 1 Senior Nutrition Programs

TEACHER RESOURCES

INTRODUCTION:

There are a wealth of resources available in the client's community. They may help improve the quality of life for the client and his/her family. Each community is unique with its available resources. The Blue Pages of the telephone directory provide a valuable listing of available help.

LESSON PLAN: 9

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

OUTLINE: (Key Points)

I COMMUNITY RESOURCES:

- A. Social Services Agencies
    - 1. Sources, functions and use of
        - a. Alcoholics Anonymous
        - b. Al-Anon, Alateen
        - c. American Cancer Society
        - d. Mental Health Department
        - e. Planned Parenthood
        - f. VNA
        - g. Other
- B. Housing Assistance (CD - 1, 3)
    - 1. Sources, functions and use of
        - a. Weatherization
        - b. Fuel assistance
        - c. Utilities
        - d. Other

C. Financial (CD - 1, 2, 4)
   1. Sources, functions and use of

      a. Food stamps - for client, whose income is low, to buy food

      b. Welfare - for client who cannot work

      c. Medicare - for client over 65 years, pays some hospital and doctor bills

      d. Medicaid - for client under 65 years, who cannot pay hospital and doctor bills

      e. Banking - loans for home maintenance

      f. Department of Income Maintenance - helps with c and d

      g. Blue pages of telephone book - lists town, state and national assistance programs

      h. Title 19 - Welfare for those in ICF and SNF with no income

      i. FISH - Emergency meals

      j. Meals-On-Wheels - 1 hot and 1 cold meal a day

      k. Other - Soup kitchens

II Summary and Conclusion

   1. Community resources

   2. Housing assistance

   3. Finances

You should know that there are ways of assisting your clients through various community resources and housing assistance programs. Alert your supervisor if you think your client has need of any of these programs.

LESSON PLAN: 9

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

CLASSROOM DISCUSSIONS:

1. What resources are available for financial help in your community?
2. Where would you look for help or information pertaining to food stamps?
3. What forms of weatherization help is available from your local utility company?
4. Explain how the Meals-On-Wheels program may help an elderly client.

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Invite guest speakers from various state or community agencies to speak to your class pertaining to the special services they offer.
2. Classroom discussions.
3. Practice calling one of the State of Connecticut toll-free telephone numbers and request specific information from a particular agency.

LESSON PLAN: 9

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

EVALUATION ITEMS:

1. List three resources available through social services agencies.

   a.

   b.

   c.

Match the group 1 social service agency to its function.

________	2. Meals-On-Wheels	a.	Federal program helping with medical costs to the elderly.
________	3. Food stamps	b.	Utility company may help insulate the client's home.
________	4. Medicare	c.	The Dept. of Income Maintenance will help a client to arrange this monthly financial aid.
________	5. Weatherization	d.	This program allows the client to stretch his/her food dollar.
________	6. Welfare	e.	A guide listing State and Municipal agencies a client may turn to for information or help.
________	7. The Blue Pages	f.	Provides one hot meal and 1 cold daily.

LESSON PLAN: 9

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

ANSWERS TO EVALUATION ITEMS:

1. a. Alcoholics Anonymous

   b. American Cancer Society

   c. Visiting Nurse Association (just 3 of the many answers, see text in Key Points)

2. f

3. d

4. a

5. b

6. c

7. e

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October 1987

Senior Nutrition Programs

Program Description

Nutrition programs for the elderly are designed to provide older Americans with low cost nutritious meals, nutrition education, and an opportunity for social interaction. The Older Americans Act of 1965 authorized two programs–the Congregate Meals Program and the Home-Delivered Meals Program.

These programs are administered federally by the Administration on Aging of the Department of Health and Human Services. Federal funds are distributed to Area Agencies on Aging in the state, which contract with local organizations to provide the congregate and home-delivered meals to participating seniors. Currently all 50 states, the District of Columbia, and all U.S. territories provide nutrition services for the elderly through these two programs.

Congressional Committees with jurisdiction over the Senior Nutrition Programs are the Senate Labor and Human Resources Committee and its Subcommittee on Aging, and the House Education and Labor Committee and its Subcommittee on Human Resources.

Eligibility

Anyone 60 years or older may participate. Their spouse, regardless of age, is also eligible.

Services are supposed to be targeted to two groups, those in "greatest economic" and those in "greatest social need." Federal rules define "greatest economic need" as including households with incomes below the poverty line. "Greatest social need" relates to any factor that restricts a person's "ability to perform normal daily tasks or threaten one's capacity to live independently," including physical and mental disabilities, language barriers, and cultural, or social isolation.

While services are concentrated on those living below the poverty level, no one may be denied service on the basis of income alone. For this reason, means testing is illegal.

Benefits

Congregate meals are usually served once a day, Monday through Friday, at a local site. In addition to meals, the following services are often provided: transportation, information and referral for health and welfare counseling, nutrition education, shopping assistance, and recreation.

The Home-Delivered Meals Program delivers nutritious meals to the homes of disabled elderly persons and others unable to leave their homes.

Participation Levels

In fiscal year 1986 (October 1, 1985 to September 30, 1986), average daily participation in the Senior Nutrition Programs was 2.9 million in the Congregate Meals Program and 670,000 in the Home-Delivered Meals Program. The need for these services is increasing with the advent of Diagnosis-Related Groups (DRG's), implemented in Medicare as a cost-containment measure. (Diagnosis-Related Groups is a system of payment in Medicare which more rigidly sets the reimbursements allowed for various kinds of hospitalizations.) Because of DRG's, older people are more likely to be sent home from the hospital earlier and require assistance in obtaining the nutritious meals they vitally need to get well and stay well.

Funding

The Senior Nutrition Programs are funded under Title III-C of the Older Americans Act. In past years the federal funding for these services has decreased. The real value of outlays for Title III-C nutrition programs has declined 23 percent from 1981 to 1986 (in 1981 constant dollars). During this same period, states, localities and the private sector have supplied additional funds to these programs and implemented cost-saving techniques to increase the number of meals served.

Funding for these programs is limited and services are provided on a first-come first-served basis. Thus, nutrition programs for the elderly are often forced to turn away people in need or to place them on waiting lists.

In fiscal year 1987, $137.2 million was appropriated for the Congregate Meals and Home-Delivered Meals Programs.

Barriers to Participation

A number of barriers to participation accentuate the nutritional risk that elderly people face. Even though transportation is supposed to be provided, access to congregate dining sites continues to be a barrier to participation. Many areas with large numbers of older people "in greatest economic and social need" are not being served by the Congregate Meals Program.

Since means testing is not allowed, some congregate meal sites are set up in more affluent areas, and it is often easier to find appropriate facilities in these areas. Thus, it is even more difficult for low-income older Americans and minority elders to reach a site.

There are not enough sites to serve all eligible people and federal funding has not significantly increased since 1981, making it that much more difficult to start up new sites.

Despite participation in the food programs, elderly participants continue to be at nutritional risk. As was reported in FRAC's *National Survey of Nutritional Risk Among the Elderly*, more than half of the elderly surveyed experience some problem buying necessary food because they lack adequate money. In a survey of Texas recipients in 1984, 34 percent said they would go hungry if it weren't for Congregate and Home-Delivered Meals. Fifty-eight percent reported that this was the only complete meal they ate during the day. Despite these findings, federal funding levels limit meal availability to five days per week.

There are not enough funds to meet the needs of all those eligible for Home-Delivered Meals.

Despite a prohibition against means-testing, many elderly people think that they cannot participate in the programs unless they make a donation.

Participation among minority groups has dropped and there is insufficient outreach to these groups to increase their involvement.

Options to Expand Participation

Federal funding should be increased to develop more sites, to increase meal service, to conduct more outreach to eligible participants, and to inform community members how to start a site.

LESSON PLAN: 10

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

SCOPE OF UNIT:

This unit covers the client's home environment including the family, types of families, changing roles of family members, types of housing, utilities and finances, care of the home environment, pest control and community resources. This unit also covers the long-term care environment.

INFORMATION TOPIC: II-10 OR DEMONSTRATION II-10
Depending on equipment available in classroom

CARE OF THE HOUSEHOLD
(Lesson title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe the importance of a clean and well maintained home environment for good health and safety and its relationship to the care plan.

2. Explain the procedures for doing laundry by machine and by hand.

3. Describe how to prevent and eliminate the invasion of household pests.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Kitchen, bedroom and bathroom facilities (Home Economics Department)

2. Laundry equipment

3. H.O. 1. Care labels are important
   H.O. 2. A short course in home laundering
   H.O. 3. Water temperature
   H.O. 4. Preparing laundry
   H.O. 5. Ways of pretreating
   H.O. 6. Detergents
   H.O. 7. Bleaches
   H.O. 8. Drying methods
   H.O. 9. Basic types of washers

   } Laundry illustrations

TEACHER RESOURCES:

INTRODUCTION:

When the client is at home, it is the nurse assistant's responsibility to keep the home neat and clean. The following lessons and demonstrations will prepare you for your role as housekeeper if there is no one in the home to do these chores.

LESSON PLAN: 10

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

SCOPE OF UNIT:

OUTLINE: (Key Points)

I. Light Household Cleaning Tasks (CD-1)
  A. The Kitchen
    1. Floors - sweep and keep free of spills, grease, grime.
    2. Trash
      a. garbage disposal
        1) always use with running cold water
        2) keep fingers away from inside of unit
        3) paper & bones stay OUT of unit
        4) freshen with baking soda
        5) grind deposited food immediately

      b. waste baskets
        1) empty once a day
        2) place sealed waste garbage bag in proper disposal unit
        3) wipe baskets before adding plastic bag
        4) line with plastic bag
        5) spray with disinfectant spray

    3. Counters
      a. clean daily with detergent and water
      b. wipe spills and crumbs; dust daily
      c. wipe/clean small countertop appliances with a special purpose cleaner after each use
      d. use 1 or 2 electric appliances per outlet

    4. Sink (CD-5)
      a. cleaning soiled items by hand washing
        1) rinse food remnants prior to washing
        2) wash in hot, soapy water in separate dish/wash pan
        3) begin with least dirty (glasses) and end with most soiled (pans)
        4) wash soldered handled knives last, do not leave in hot water
        5) rinse all items in hot water
        6) drain in dish drainer, air dry
        7) return to proper places

- b. cleaning soiled items by automatic dish washer
    - 1) rinse all items prior to placing in dishwasher
    - 2) place glasses and cups upside down on top rack
    - 3) place dishes and heavier items on bottom rack
    - 4) place flatware and some utensils in basket intended to hold them
    - 5) fill soap dispenser with recommended amount of liquid or powdered dishwasher detergent
    - 6) run dishwasher when filled to capacity
    - 7) empty dishwasher when cycle is completed
    - 8) return items to proper places
    - 9) wipe exterior with special-purpose cleaner daily

- c. cleaning the sink
    - 1) scrub with cleanser daily, rinse residue
    - 2) scrub faucets and spigot daily with cleanser, rinse well, dry
    - 3) scrub sink drain catch daily with cleanser
    - 4) remove any food remnants from drain catch

5. Cabinets
    - a. doors---keep closed when not in use
    - b. interior---place items in neat, logical order
        - 1) store items used daily/frequently within reach. Store heavy items on lower shelves
    - c. wipe exteriors weekly using a special purpose cleaner

6. Refrigerator (CD-4)
    - a. wipe exterior daily with special purpose cleaner
    - b. dust top weekly
    - c. clean interior weekly with a solution of baking soda and warm water. Shelves and drawers may be washed with hot sudsy water.
    - d. foods should be covered
    - e. check contents daily for old or spoiled food; discard leftovers if not used in 3 days
    - f. each month, remove shelves and drawers. Wash in hot water and detergent. Rinse.

6. Stove
   a. Wipe daily with a special purpose cleaner.
   b. Clean stove front and sides weekly using a special purpose cleaner.
   c. Clean burner pans weekly. Wipe using a damp sponge or with a special purpose cleaner.
   d. Wipe spills immediately.

7. Miscellaneous Appliances
   a. Microwave
      1) Wipe exterior daily with a special purpose cleaner.
      2) Clean interior with a mild solution of soap and water following each use.
      3) Keep edges of door and opening free of any soil.

   b. Toaster Oven/Broiler Oven
      1) Scrub interior trays using hot soapy water and/or steel wool pad after each use
      2) Wipe exterior weekly using a special purpose cleaner
      3) Unplug when not in use

   c. Toaster
      1) Empty crumb tray after each use
      2) Wipe exterior with special purpose cleaner after each use.
      3) Unplug when not in use

B. The Bathroom
   1. Toilet
      a. Monthly, clean interior of tank with a liquid or solid special purpose cleaner.
      b. Weekly, clean exterior of tank and bowl using a special purpose cleaner.
      c. Weekly or more frequently, using a bowl brush and a special purpose cleaner, scrub the interior of the bowl, rim and under rim. Flush.
         1) Some cleaners cannot be combined together. Read and follow manufacturers' instructions.

   2. Bathtub and shower
      a. After each use, use sponge or cloth to remove soap residue. Towel dry.
      b. Weekly, scrub tub or shower stall/walls with a special purpose cleaner. Rinse well, towel dry.
      c. After each use, air dry shower curtain.
      d. After each use, towel dry shower doors. Weekly, clean with special-purpose cleaner.

3. Sink
See instructions for "cleaning the sink in the kitchen".

4. Linens
- a. Provide fresh towels daily
  - 1) Place within easy reach of client
- b. Place soiled linens in appropriate area

5. Floor
- a. Sweep daily
- b. Shake scatter rugs outside to remove dust
- c. Keep free of water

6. Waste Baskets
- a. Empty once a day
- b. Line with plastic bag
- c. Spray with disinfectant

C. Bedroom
1. Bed
- a. make daily (see unit - Personal care)
- b. fluff pillows daily
- c. fresh sheets, pillow cases weekly or more often as needed
- d. change mattress pad monthly
- e. reverse mattress monthly

2. Furniture
- a. tidy tops daily
- b. close drawers
- c. shake doilies free of dust weekly
- d. dust with cloth and dusting spray twice a week

3. Floors
- a. sweep or vacuum twice a week

II. Laundry
A. Laundry aids and supplies
1. Detergents and soaps (either liquid or powder)
2. Bleach
   - a. chlorine or all-fabric (oxygenated)
3. Pre-treating
   - a. enzyme presoaks and stain removers
4. Fabric softeners
   - a. in detergent or a separate liquid
5. Dryer sheets to control static cling

B. Laundering
1. Washing machine - in home or laundromat
   - a. types such as top or front loading, portable, combination washer/dryer, wringer.
   - b. follow directions on machine for water temperature, length and type of cycle and detergent.

        2. Hand washing as requested by client or recommended on clothing label.

        3. Drying with dryer
            a. types (combination washer-dryer, front loading)
            b. follow directions on machine
            c. remove lint after each use

        4. Line Drying - indoor/outdoor

        5. Flat drying - on rack or towel

    C. Laundering tasks (CD-2)
        1. sort (by color, fiber content, amount of soil).
        2. pretreat
        3. choose proper water temperature
        4. choose washing products
        5. choose washing cycle
        6. rinse
        7. dry
        8. fold
        9. iron/press
        10. return to storage area

III. Pest Control
    A. Prevention
        1. keep foods covered
        2. store foods in appropriate area (ie. refrigerator, cabinets)
        3. discard old or spoiled foods on a regular basis
        4. keep work surfaces and floors clean and grease-free

    B. Recognize signs of pests (CD-3)
        1. roaches - (walking anywhere)
        2. rats, mice - (droppings)
        3. ants - (on floor or walls)
        4. mosquitoes - (flying)
        5. ticks - (seen on skin)
        6. fleas - (itching skin)

    C. Solving the problem
        1. keep home clean
        2. special-purpose insect spray
        3. professional pest control

    Summary and Conclusion:
        1. light household cleaning tasks
        2. laundering tasks
        3. pest control

You should be able, effectively, to clean various rooms in your client's home. You may also be required to do laundering tasks such as sorting linen, pretreating, washing, drying, folding and putting it away. Keep a watchful eye open for unwanted pests. The client and his/her family will count on your skills to help make the home more comfortable and clean.

LESSON PLAN: 10

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

CLASSROOM DISCUSSION:

1. What are some examples of household cleaners?
2. Describe how to sort laundry.
3. Describe products available for home pest control.
4. How should food be stored in the refrigerator?
5. How do you wash dishes by hand?

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Demonstration of cleaning, washing clothes.
2. Discuss pesticides.
3. Discuss proper storage of foods and non-food items such as cleansing items.

LESSON PLAN: 10

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

________ 1. The trash should be emptied once a day.
________ 2. Glasses are washed last.
________ 3. Ideally, dishes should be air-dried.
________ 4. Wash dishes in hot water; rinse in cold water.
________ 5. The interior of the refrigerator is cleaned using a solution of baking soda and water.
________ 6. The stove should be kept grease free.
________ 7. Steel wool is the best choice for cleaning a stove top.

Below is a list of household tasks. Some should be performed daily, some weekly and some only occasionally. Place a "D" for tasks performed daily, a "W" for weekly and an "O" for those done occasionally.

________ 8. Kitchen sink
________ 9. Scrub bathtub/shower stall
________ 10. Wipe bathtub/shower stall
________ 11. Toilet bowl
________ 12. Stove top
________ 13. Exterior of refrigerator
________ 14. Interior of refrigerator
________ 15. Bathroom sink
________ 16. Make bed
________ 17. Dust

List 3 products you may use to wash clothes.

18. ________________________
19. ________________________
20. ________________________

Place the following laundering tasks in the order you would do them.

Order	Tasks
_____ 21.	a. dry
_____ 22.	b. choose washing products needed
_____ 23.	c. fold
_____ 24.	d. sort
_____ 25.	e. determine washing cycle
_____ 26.	f. return to storage
_____ 27.	g. iron
_____ 28.	h. pretreat

Name 3 common household pests.

29. ______________________________

30. ______________________________

31. ______________________________

LESSON PLAN: 10

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

ANSWERS TO EVALUATION ITEMS:

1. T
2. F
3. T
4. F
5. T
6. T
7. F
8. D
9. W
10. D
11. W
12. D
13. D
14. W
15. D
16. D
17. W
18. laundry detergent
19. bleach
20. pretreatment or fabric softener
21. d
22. b
23. h
24. e
25. a
26. c
27. g
28. f

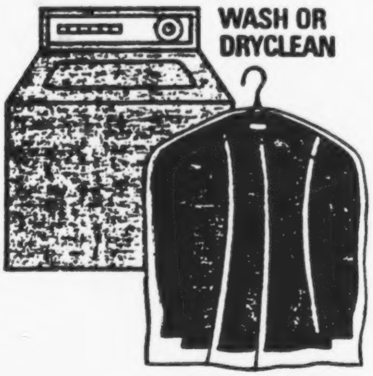
29.)
30.) any - roaches, rats, mice, ants,
31.) mosquitoes, ticks, fleas

Care labels are important

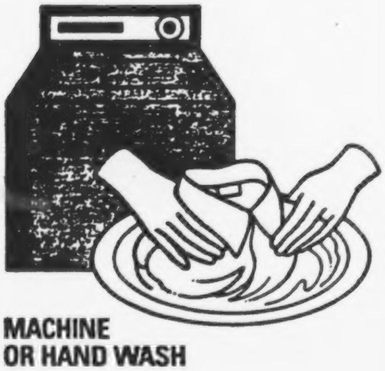
Look to your new care labels for answers to your cleaning questions.

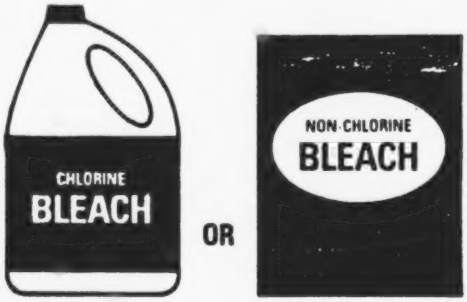
Chances are that you know about labels and use them to help you safely clean your clothes. The Care Labeling Rule, which requires that care labels be placed in textile clothing, was recently revised by the Federal Trade Commission. The new care labels began appearing in 1984.

1. WASH OR DRYCLEAN? The new care labels will tell you if your garment should be washed or drycleaned. Some labels may provide information about both methods of care.



2. MACHINE OR HAND WASH? If a garment requires washing, the new label will tell you if it should be washed by machine or hand. If special water temperatures are required, they will be shown on the label (e.g., "machine wash, warm").





3. BLEACHING? Many of today's fabrics, including colored fabrics, need bleach as well as detergent to help get them clean and free from stains and soils.

When a new care label doesn't mention bleaching, or says "bleach when needed," you can safely use any bleach, chlorine or non-chlorine. For example:

MACHINE WASH
TUMBLE DRY

=

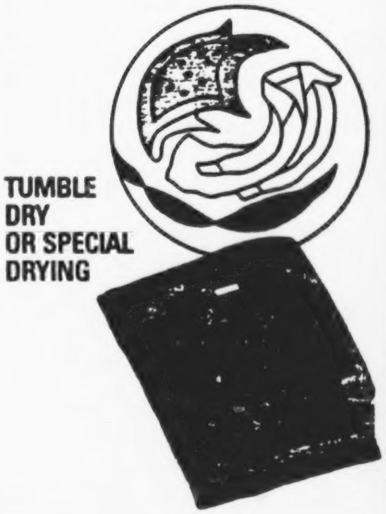
MACHINE WASH
BLEACH
WHEN NEEDED
TUMBLE DRY

The new care label will tell you when to use non-chlorine bleach if chlorine bleach is not appropriate. For example:

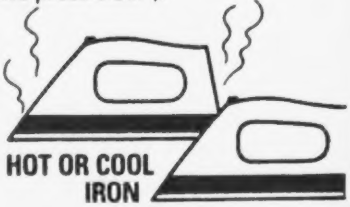
MACHINE WASH
ONLY NON-CHLORINE BLEACH
WHEN NEEDED
TUMBLE DRY

Whenever bleaching, be sure to follow the new care label and package instructions carefully.

4. TUMBLE DRY OR SPECIAL DRYING? The new care instructions will tell you the proper way to dry your garment. If special drying procedures or temperatures are required, they will be include on the label (e.g., "tumble dry, low" or "dry flat").



5. IRONING? If a new care label does not mer tion ironing, no ironing is necessary. If ironing is required, the label will provi an ironing instruction. If the garment r quires special handling, specific instr tions will be included (e.g., "cool iron" "use press cloth").



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A SHORT COURSE IN HOME LAUNDERING

TO WASH

SORTING THE LOADS

Sorting clothes for washing is more important than it ever was because of the many varieties of articles in today's wash loads. Sort by fabric and construction, grouping together those articles which can be washed at the same water temperature, agitation and spin speed. Further sort for degree of soil, color, (keeping whites separate) and lint shedding properties.

DURABLE PRESS, WASH and WEAR and SYNTHETIC FABRICS

Articles made of the above fabrics have characteristics in common and will require the same washing methods, as determined by color, soil, construction, and delicacy of fabric.

Durable Press will require little or no ironing if label precautions are taken. Most new washers have durable press wash cycles which cool the clothes after the wash and before the wash spin, to prevent spin wrinkles. Warm or cold wash water will cause fewer spin wrinkles but hot water is sometimes needed for adequate soil removal. Always use a cold rinse and slow spin when possible. Other rules for durable press are: wash and dry in small loads, wash frequently, pretreat greasy stains, use adequate detergent and wash whites separately.

DRYER DRY DURABLE PRESS FOR BEST RESULTS. Remove clothes as soon as tumbling stops.

KNITS

Knit fabrics may be made from almost any fiber or combination of fibers. Those made from or containing a high percentage of man-made fibers are the most shrink resistant. Knits of cotton, rayon, acetate or wool can be stretched or pulled out of shape during manufacture and may shrink from being wet (wash water or rain) unless they have been treated with a shrink resistant finish. Look for labels which indicate fiber content or shrink resistance.

FOLLOW THE MANUFACTURER'S CARE INSTRUCTIONS

In general, observe the following rules for knits.

TO WASH KNITS

Sort for color, fabric weight, construction and soil. Knits snag easily so turn garments inside out. Avoid washing with hooks or sharp objects. Do not wash with heavy fabrics because knits could be pulled out of shape.

Avoid extreme conditions such as hot water and long washing. Use the Durable Press washer cycle for knits of man-made fibers. This provides the proper cooling after washing and before spinning to minimize wrinkling.

TO DRY KNITS

Use the heat setting suggested by the garment or dryer manufacturer. Dry with similar weight fabrics. Avoid overdrying to minimize shrinkage. Remove from dryer when just dry or slightly damp.

GET RID OF TROUBLEMAKERS

A little time in preparing the clothes will be well spent. Shake dirt and sand out of trouser cuffs and pockets, remove all items from pockets and remove perishable trim. Check for colorfastness, buckles and pins that rust.

Mend tears. Little holes have ways of becoming bigger. Also, close zippers, tie belts and sashes and close hooks so they will not catch on other garments.

Look for stains and badly soiled places. Stains are more easily removed when fresh. Pretreat collars, cuffs and heavily soiled places by applying liquid detergent to the area before washing. For grease stains on durable press, apply liquid detergent or detergent moistened in water and let this remain on the stain for at least an hour before washing.

LOAD THE WASHER PROPERLY

Judge the size of the washer load by bulk rather than b pounds as fabrics vary in weight. Load the washer loosel with dry clothes to the top of the agitator vanes for a fu load. The clothing should move freely in the water. Was durable press in smaller loads to minimize wrinkling.

WATER IS IMPORTANT

If water is "hard", have it mechanically softened i possible. Wash water for general laundry should be 140 - 145° in the washer. Do not use soap in hard water.

USE THE CORRECT WASHING RECIPE

The use of too little detergent is the most common caus of unsatisfactory washing results. Washers vary in size s follow the washer manufacturer's directions because eac brand will require its own recipe. For most laundry, us an all-purpose detergent and note the package direction as different brands may require different amounts. Extr detergent is needed for hard water, heavy soil, coole wash water and gentle agitation. Cold water detergen may be used in hot water. Hot water will remove the mo soil.

NONPHOSPHATE DETERGENTS

The results from using some nonphosphate detergen may not be up to industry standards. Be aware that s removal may not be as good as usual. Clothes may b come stiff which can cause thread breakage. A coati may be formed on fabrics which will cause colors to lo faded. This may sometimes be removed by washing t clothes with a phosphate detergent.

Observe the cautions on these package labels if advis to keep out of the reach of children, as permanent inju may be caused if these alkaline detergents are accident swallowed or if they come in contact with the eyes.

YOU MAY WANT TO SOAK SOME LOADS

Some soils such as those from protein foods, blood, diaper soil, perspiration, etc. will be set by hot water. Soak or pre-wash them first using the soak or rinse portion of the cycle, and an enzyme pre-soak product or detergent. For a longer soak, stop the washer for 30 minutes or longer. After the soak time, start the washer and spin the water out of the clothes. Follow the soak or pre-wash with a hot wash and more detergent.

BLEACH IF YOU WISH

Bleach serves a useful purpose in whitening and brightening clothes. You may want to bleach every several washes or as needed. Chlorine bleach is the most effective stain remover and will be necessary for the removal of some stains. Chlorine bleach is most effective in the hot wash water with detergent. In washers with automatic bleach dispensers, the bleach will be added midway in the wash cycle, for best results. If bleach is added manually, add it after washing has started or at the beginning of the wash, whichever is the most convenient. The usual amount of liquid chlorine bleach is one tablespoon of bleach for each gallon of wash water. CHLORINE BLEACH MUST BE DILUTED in a quart of water before it is added to a clothes load. Clothes will be damaged if undiluted chlorine bleach comes in contact with them. Chlorine bleach is a good disinfectant and is especially good to use when washing "sick room" laundry.

Chlorine bleach may be used on white durable press, white nylon and white polyesters. DO NOT USE CHLORINE BLEACH on wool, silk, spandex, nonfast colors and on any fabric whose hang tag warns against this. All-purpose bleach and oxygen bleaches are safe for these fabrics.

ABOUT FABRIC SOFTENERS

Liquid fabric softeners add softness and ironing ease and will remove the static electricity which causes man-made fibers to cling. Follow manufacturer's directions for use. Undiluted fabric softener may stain clothes. To remove, rub with bar soap or soak in hot water with sufficient detergent.

WE DO NOT RECOMMEND THE USE OF A SPRAY FABRIC SOFTENER IN THE DRYER.

DINGY CLOTHES

Clothes may be grey or have yellow centers from unremoved soil. The cause may be wash water not hot enough, the use of too little detergent, overcrowding the washer or a combination of these. To improve the appearance, soak the clothes in hot water with twice as much detergent as usual. Then wash with hot water and chlorine bleach if suitable for the fabric. The treatment may need to be repeated.

Yellow streaks or a yellow color may be caused from iron in the water. Phosphate detergents will usually hold the iron in suspension in the wash water. Most of the non-phosphate detergents do not have this property and consistent use of them may cause yellowing if iron is present in the water.

CAUTION! White synthetic fabrics should not be washed and dried with any type of colored garments, even though colorfast. Nylon, Orlon, etc., will readily pick up color, even from colorfast fabrics.

FORM NO. 9-74-92
(Supersedes 882AR3)

TO DRY

AUTOMATIC DRYING

Automatic drying is perhaps the easiest phase of laundering. It requires only a little knowledge and planning to turn out fluffy, sweet smelling clothes all the year round regardless of the weather. To insure successful drying, try these helpful hints.

SORT THE CLOTHES

Sort loads according to fabric weight. Generally clothes that are washed together can be dried together. Do not mix lint shedding with lint receiving fabrics.

LOADING HAS A FEW RULES

The size of the load is as important in the dryer as it is in the washer. More than a normal load slows drying action, cuts down that "fluff" you want in clean clothes. If you have a very small load, add a few bath towels as buffers to aid tumbling action. Don't add wet or damp clothes to a partly dried load. This increases drying time.

FOR MORE EFFICIENT DRYING

Do keep the lint screen clean. Air flow will be cut down and drying time increased if lint screen is blocked. Don't open dryer door too often.

DON'T OVERDRY

Remove clothes from the dryer before they are "bone-dry". Overdried clothes may be harsh and wrinkled if all the natural moisture is removed. Overdrying may cause shrinkage in cotton knits. Remove regular cotton sheets and pillowcases with a trace of moisture remaining, fold and smooth them and they will probably need no ironing. Be sure to dry durable press fabrics in the dryer. Don't crowd these items and remove them as soon as they are dry and tumbling stops, then hang or fold them. To eliminate sprinkling, remove clothes which are to be ironed with "ironing dampness" remaining. Fold them, place in a plastic bag until they are ironed.

FOR SAFETY'S SAKE

Some materials are fire hazards or explosive hazards because of their composition. Dry with AIR ONLY, NO HEAT, articles containing FOAM RUBBER or similarly textured rubber-like materials and Kapok. This includes padded bras, stuffed animals, rubber backed rugs and foam rubber pillows. DO NOT USE HEAT for plastics which may melt. Watch the hang tag directions for anything which says "DRY AWAY FROM HEAT".

DO NOT USE THE DRYER FOR anything which has been dry cleaned at home with flammable or combustible fluids. The dryer is intended only for articles which have been washed with water.

DO NOT USE THE DRYER for anything containing wax or chemicals such as dust mops or cleaning cloths unless these chemicals have been thoroughly washed out.

Permanently pleated skirts, fiber glass materials, and loosely knit woolens should not be dryer dried. See dryer instructions for washable woolens.

Home Service Department
SPEED QUEEN
a McGraw-Edison Company Division
Ripon, Wisconsin 54971

IMPORTANT LAUNDERING INFORMATION

HO 3-9

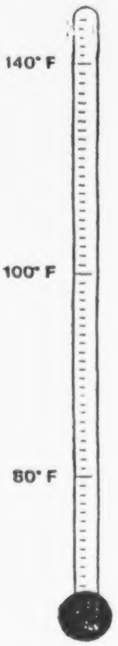
Water Temperatures

3

1. Why use HOT water?

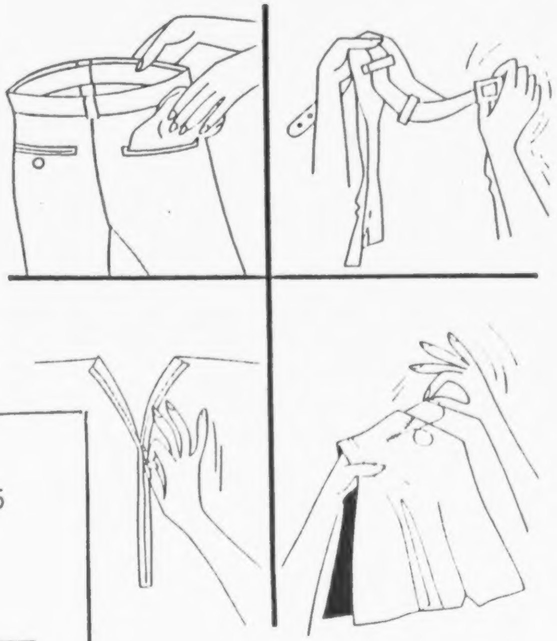
2. Why use WARM water?

3. Why use COLD water?


140° F
100° F
80° F

Preparing Laundry

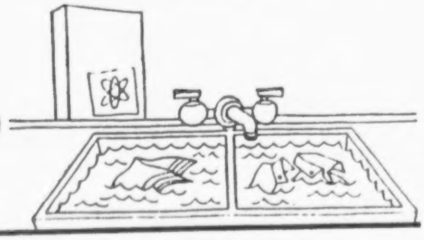
4



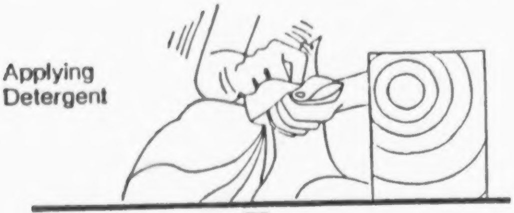
Ways of Pretreating

5

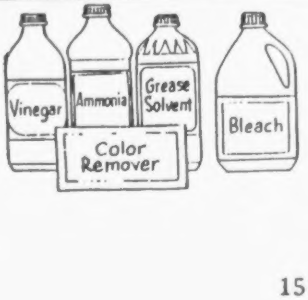
Soaking



Applying Detergent

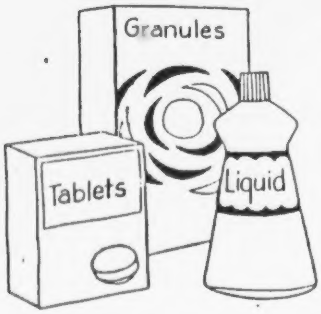


Special Treatments

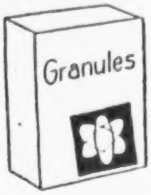

Vinegar
Ammonia
Grease Solvent
Bleach
Color Remover

6

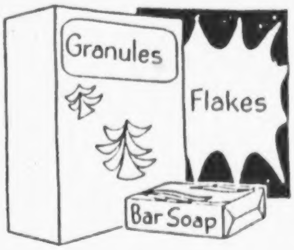
Detergents


Granules
Tablets
Liquid

Enzyme Detergent Booster/Pre-soak Products

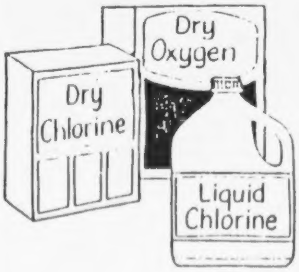


Soaps


Granules
Flakes
Bar Soap

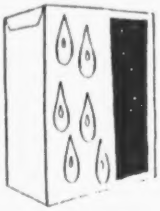
7

Bleaches

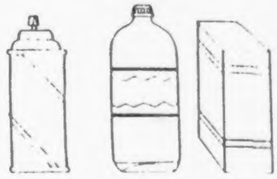

Dry Oxygen
Dry Chlorine
Liquid Chlorine

Fabric Softener

Water Softener



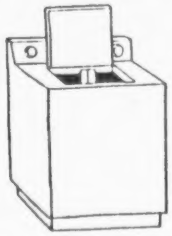
Starches



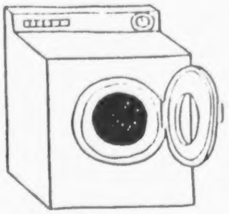
Aerosol Liquid Dry

5 Basic Types of Washers

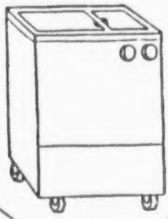
8



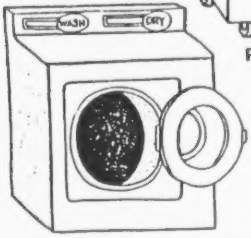
Top-Loading Automatics



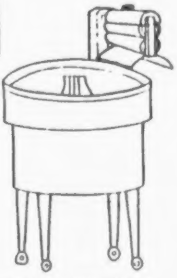
Front-Loading Automatics



Portables



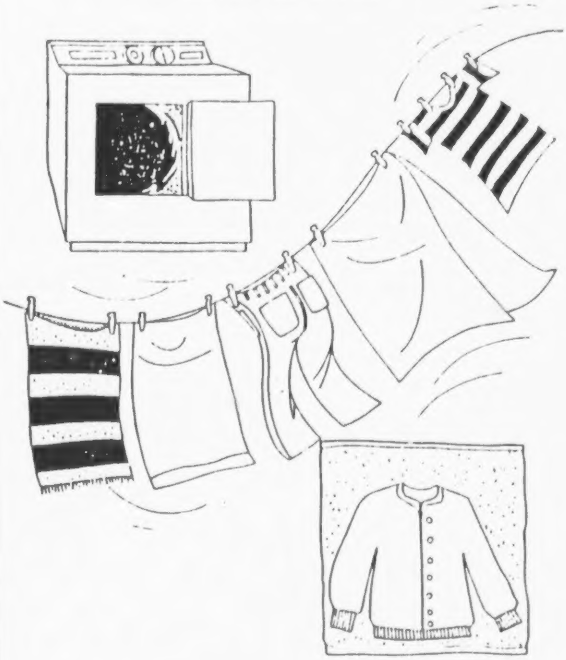
Combination Washer-Dryers



Wringer Washers

Drying Methods

9



LESSON PLAN: 11

COURSE TITLE: NURSE ASSISTANT

UNIT II: THE CLIENT'S ENVIRONMENT

SCOPE OF UNIT:

This unit covers the client's home environment including the family, types of families, changing roles of family members, types of housing, utilities and finances, care of the home environment, pest control and community resources. This unit also covers the long-term care environment.

INFORMATION TOPIC: II-11 OR DEMONSTRATION:

ORIENTATION TO THE LONG-TERM CARE ENVIRONMENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify areas in the facility used by the nurse assistant.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Client's bed

2. Signal Light

TEACHER RESOURCES:

INTRODUCTION:

It is important for the nurse assistant to take a look at the long-term care environment--the surroundings. We must always keep in mind that this is the client's home, oftentimes, his or her final dwelling. Certain equipment is found in all rooms. It is one of your responsibilities to keep the client's room neat, clean, and safe. Report any hazardous condition immediately. Occasionally check bedside stands for spoiled food, matches, etc. You should also be aware of the purpose and placement of other areas within the facility.

LESSON PLAN: 11

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE CLIENT'S ENVIRONMENT

OUTLINE: (Key Points)

I. The Environment - the physical surroundings (may include emotional)

  A. Resident unit

    1. Room may be a ward, private, or semiprivate

    2. Bed, mattress, pillow, and bedding

    3. Bedside table

      a. Store client's personal possessions-including brush, comb, electric razor, toothbrush (check facility policy regarding what can be kept)

      b. Equipment needed for his/her care

        1) Water pitcher and drinking glass

        2) Bath basin and linen

        3) Emesis basin and mouth care equipment

        4) Soap and soap dish, lotion or powder

        5) Bedpan and cover

        6) Urinal and cover

    4. Comfortable chair; may have own furniture from home

    5. Reading lamp

    6. Personal storage drawers and closet

    7. Signal light or appropriate call bell

      a. Place in reach of client at all times

      b. Answer promptly and then turn it off, unless more help is needed

      c. Anticipate needs of helpless clients

    8. Privacy curtain or screen
    9. Overbed table, commode, wheelchair, geriatric chair if needed.

B. Utility rooms (CD-1)

    1. Dirty utility room
        a. Emptying, cleaning, and disinfecting of utensils
        b. Storage of nonsterile equipment
        c. Urine testing
        d. Soiled linen storage
    2. Clean utility room
        a. Processing of sterilization
        b. Storage of sterile and clean supplies

C. Dining room

    1. Where clients eat all meals
    2. Position clients properly at tables to eat.
    3. Assist clients to eat or feed helpless clients.
    4. Monitor food and fluid intake.

D. Activity room

    1. Where group activities occur
    2. Assist with activities when nursing routine allows.

E. Nurse's station

    1. Reporting
    2. Recording
    3. Receiving assignments
    4. Review of care plans

II. Summary and Conclusion

1. The environment

Remember how important it is to keep the client's environment clean, neat, and comfortable at all times. It is his/her home!

LESSON PLAN: 11

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What areas in the long-term care facilities are most frequently utilized by the nurse assistant?
2. How would you feel if you knew the long-term care facility was your last place to live? What could make it better?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Have students locate and operate all equipment in client's living area.

LESSON PLAN: 11

COURSE TITLE: NURSE ASSISTANT

UNIT II: THE NURSE ASSISTANT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 1. The signal light should be placed near the resident only when the client is in the bed.

_______ 2. Urine is tested in the dirty utility room.

_______ 3. Sterile supplies are kept in the clean utility room.

_______ 4. The nurse assistant monitors food or fluid intake in the dining room.

LESSON PLAN: 11

COURSE TITLE: NURSE ASSISTANT

UNIT II : THE NURSE ASSISTANT

ANSWERS TO EVALUATION ITEMS:

1. F

2. T

3. T

4. T

7824U

LESSON PLAN: 12

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-12 OR DEMONSTRATION:

MENTAL HEALTH/MENTAL ILLNESS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List some characteristics of good mental health.
2. Name 2 coping mechanisms.
3. Define mental illness.
4. Name 2 types of mental illness.
5. Identify 3 abnormal behaviors of a client who has been diagnosed as mentally ill.
6. List 2 ways the N.A. may interact with a client who demonstrates withdrawal.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

Videos - American Health Care Association
"Observe and Report" #91
"Keep Going Straight" #27
"Dealing with Depression" #46

Video Tape Player

TEACHER RESOURCES:

INTRODUCTION:

Many of your clients will behave abnormally. These behaviors may have an emotional/psychological basis or may have an organic/functional basis. First you will learn about mental health and how persons normally react to stress (coping mechanisms). Also, you will learn some things about mental illness and how mentally ill clients behave. You will also learn some methods of caring for these clients.

LESSON PLAN: 12

COURSE TITLE: NURSE ASSISTANT

UNIT III: THE CLIENT

OUTLINE: (Key Points)

I Definitions:

A. Mental Health: Most behaviors have an appropriate range which is acceptable and expected. The following statements may be used to judge what is GOOD MENTAL HEALTH: CD-1

1. Good feelings about oneself; express or communicate one's emotions; seldom feel inadequate or inferior.
2. Make decisions after considering consequences and act on those decisions.
3. Feel well and have a positive outlook.
4. Develop one's strong points and accept real limitations.
5. Learn from one's mistakes and do not repeat mistakes.
6. Delay gratification for a better future. (Example: sex encounter, early marriage, cheaper coat vs better coat)
7. Form close and long friendships with both sexes; enjoy an active and good sex life; be satisfied with sex identity.
8. Cannot hurt self or others because of a conscience that will produce guilt when one's behavior is damaging or unsocial.
9. Accept authority, live by rules, etc., but, when appropriate, question authority or rules.
10. Meet one's needs while considering needs of others.
11. Small jealousies and the use of others for one's own good are not part of one's life.
12. See reality as accurately as possible especially in one's social and interpersonal relationships.
13. Work well alone and with others; adjust "give and take" to appropriate situation; have clean, prompt, orderly and neat personal habits.
14. Accept roles of being dependent, independent and of being a leader or follower as situations occur throughout life.
15. Adapt to stress and change with minimum emotional upset by being appropriately flexible.
16. Laugh at self and others when situations are as absurd as they are funny.
17. Maintain personality that fits each life situation.

Adapted from Bailey, David S. and Sharon O. Dreyer, Therapeutic Approaches to the Care of the Mentally Ill, Philadelphia: F.A. Davis, 1984

B. Some coping or defense mechanisms used by everyone to protect self from stressful situations: HO-2

1. Repression - forgetful, feels guilty without knowing why.
2. Rationalization - Makes "acceptable" excuses for behavior.
3. Projection - blames one's shortcomings on other people or objects.
4. Regression - behavior that takes one back in time of development where one felt more comfortable.

C. Mental Illness - Severe personality changes that affect thinking and behavior which interfere with work, social relationships and contact with reality.

II Some names of mental illnesses whose symptoms usually start slowly and take time to be noticed. HO-3

ILLNESS	SOME SYMPTOMS
A. Depression (most common)	sleeplessness, loss of appetite, withdrawal, low energy level
B. Manic Depression	wide swings in behavior and thinking from very fast to very slow over longer periods of time
C. Schizophrenia	
1. Simple	loss of interest in self and surroundings
2. Paranoid	hostile, suspicious, aggressive
3. Hebephrenic	inappropriate laugh or giggle
4. Catatonic	extreme withdrawal, motionless for hours or days.
D. Paranoia	grandiose delusions of persecution, hostile, better intellectual control than schizophrenia

E. Dementia - many causes and can include such terms as:	
1. Organic brain syndrome	Apathy, memory loss, speech impairment, disorientation, poor judgement
2. Organic psychosis	
3. Senile dementia	
4. Alzheimer's Disease	
5. Toxic dementia	
6. Traumatic brain injuries	
F. Neuroses/Hysterics	Mild interference with social, work or sexual associations; not harmful to self or others
G. Other	
1. Obsessive Compulsive	repeating rituals
2. Phobias	fears

III Some causes of mental illness:

A. Unknown
B. High fever, infection
C. Substance use (alcohol, illegal drugs, prescribed drugs)
D. Loss, deprivation, isolation
E. Degenerative diseases of age
F. Genetic
G. Traumatic Brain Injury

IV Some treatments for mental illness:

A. Medical doctors including psychiatrists, evaluate, diagnose and treat with or without drugs
B. Individual and group therapy
C. Care givers (N.A.) trained to observe thinking and behavior changes. Also trained to objectively report these changes to R.N. or L.P.N.
D. Institutionalization, group homes

V Nurse Assistant, after learning about normal mental health, must:
A. Know symptoms of mental illness
B. Observe changes and objectively report
C. Be friendly and interested
D. Encourage client to be involved in his/her own A.D.L.
E. Speak to client in normal voice, in a simple style and not use "baby talk".

VI Summary and Conclusions:

A. Good mental health
B. Coping mechanisms
C. Mental illness - names and symptoms
D. Causes of mental illness
E. Treatments for mental illness
F. Nurse Assistant's role in care of clients who are mentally ill.

CONCLUSIONS:

A mentally healthy person has a set of behaviors that allow him/her to fit into society - at home, work, school or play. Each person has methods of dealing with stressful situations and these fit into society. However, some persons exhibit behaviors that are outside this fit. These behaviors may translate into specific names for mental illnesses. You have learned something about these illnesses and will care for clients who need your help. Always treat clients with dignity and be non-judgemental about behaviors before, during and after treatment.

LESSON PLAN: 12

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. Discuss 2 good mental health behaviors.
2. Have you ever used a coping mechanism?
3. Why do you think isolation can cause mental illness?
4. Discuss objective reporting.

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Role play types of mentally ill behaviors.
2. Role play a N.A. interacting with these behaviors.
3. Invite a psychiatric social worker to class to discuss his/her occupation.

LESSON PLAN: 12

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

I For each of the following, write N if the statement is normal or write A.B. if the statement is abnormal behavior.

_______ 1. Motionless for hours
_______ 2. Good feelings about self
_______ 3. Withdrawal
_______ 4. Loss of interest in surroundings
_______ 5. Learns from mistakes
_______ 6. Makes decisions after considering consequences
_______ 7. Usually accepts authority
_______ 8. Keeps up A.D.L.
_______ 9. Grandiose ideas
_______ 10. Loss of memory
_______ 11. Can work alone or with others as necessary

II Match the coping mechanism with the correct definition by placing the correct letter in the blank.

_______ 12. Projection	a.	Forgets, feels guilt not knowing why
_______ 13. Rationalization	b.	Moves backward in time
_______ 14. Regression	c.	Making acceptable excuses for behavior
_______ 15. Repression	d.	Blames someone else or object for shortcomings

III For each of the following, mark "T" if the statement is true and" F" if the statement is false.

_______ 16. Substance use may cause some forms of mental illness.
_______ 17. Diseases of old age may cause some forms of mental illness.
_______ 18. Having a positive outlook may cause some forms of mental illness.
_______ 19. Mentally ill clients cannot be treated.
_______ 20. Caregivers of mentally ill clients do not need to observe clients' behaviors and emotions.
_______ 21. All mentally ill clients are sent to institutions for treatment
_______ 22. The nurse assistant must be interested and friendly when caring for mentally ill clients.

LESSON PLAN: 12

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. AB
2. N
3. AB
4. AB
5. N
6. N
7. N
8. N
9. AB
10. AB
11. N
12. d
13. c
14. b
15. a
16. T
17. T
18. F
19. F
20. F
21. F
22. T

LESSON PLAN: 13

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-13 OR DEMONSTRATION:

DEVELOPMENTAL DISABILITIES (MENTAL RETARDATION)
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define developmental disabilities.
2. List 3 causes of developmental disabilities.
3. Describe 1 way to improve a developmentally disabled client's self image.
4. List 2 ways that may prevent a developmental disability.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

Film: "World of Right Size" - source unknown

"Sarah Has Down's Syndrome - State of Connecticut Home Economics Film Library

16 m.m. Projector

TEACHER'S RESOURCES:

INTRODUCTION:

In your client assignments, you may be responsible for the care of a person who has a developmental disability; or a developmentally disabled person may be part of your client's family. It is important to recognize this developmentally disabled person on first contact by speaking to him/her and giving special attention to skills he/she may have to assist you with his/her care or your client's care, if possible. This class will give you some information about the developmentally disabled person.

LESSON PLAN: 13

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

I Definition - Impairment in ability to learn and adapt socially. (CD-1)

I.Q.-	Borderline	71-84	)
	Mild	50-70	) client's education
	Moderate	35-49	) and training based
	Severe	20-34	) on these scores
	Profound	below 20	)

II Some causes are

- A. Pre-natal birth defect
  ex: chemicals, injury, Down's Syndrome
- B. Birth injury
  ex: difficult birth, cord around neck-anoxia
- C. Traumatic brain injury after birth (CD-2)
  ex: fall on head, auto injury involving head
- D. Genetic defect - (CD-3)
  ex: Tay Sachs, P.K.U.
- E. Emotional and/or social isolation
  ex: abuse, neglect
- F. Substance abuse
- G. Unknown - brain tumor? - infection?

III Care: Must meet physical and emotional needs (see general population - Lesson 14)

- A. Since physical problems may accompany developmental disabilities, care is modified to the individual client according to the care plan.
- B. Emotional care involves love, a home, food and a safe environment especially in feeding and ambulation. (CD-4)
  1. must encourage a positive self-image
  2. must offer choices for positive behavior
  3. must be able to learn and work at a slower pace to the best of the client's ability

IV Prevention of some development disabilities (CD-5)

A. Good obstetrical care for all pregnant women - pre and post delivery

B. Prepared parents who provide love, food and safety for each child

C. Immunizations

D. Genetic counseling to prospective parents, if necessary

V Summary and Conclusions

A. Definition of developmental disabilities

B. Some causes of developmental disabilities

C. Care necessary for developmentally disabled clients

D. Some ways developmental disabilities can be prevented.

Remember that these clients often have physical and emotional problems. Each developmentally disabled client must be treated so he/she may succeed to the best of his/her ability to ensure a good self-image. Keep in mind that some of these problems can be prevented in future generations through good pre-natal care.

LESSON PLAN: 13

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. How would you recognize a developmentally disabled client?
2. If you are in charge of a child, why will you try your best to prevent a head injury?
3. Name (1) cause of developmental disabilities.
4. Do you think a developmentally disabled client can have emotional problems?
5. Can some developmental disabilities be prevented?

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Visit a Regional Center.
2. Visit a large state institution for the developmentally disabled.
3. Visit and involve students in a high school class for the developmentally disabled.
4. Ask a parent of a developmentally disabled person to visit the class to discuss what family life is like for them.

LESSON PLAN: 6

COURSE TITLE: NURSE ASSISTANT

UNIT I : THE NURSE ASSISTANT

CLASSROOM DISCUSSION:

1. What methods might you use to observe the client?
2. What observations should you make about the way your client appears to you?
3. What observations should you make with regard to your client's behavior?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Write a short paragraph about another classmate or a client after observing him or her for a few minutes (use all observation methods, if applicable).
2. Show filmstrip.
3. Go to clinical area--observe edema, lung congestion, reddened areas, etc.
4. Flash cards to assist with learning terminology.

LESSON PLAN: 13

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true or "F" if it is false.

_______ 1. A developmentally disabled person is usually delayed in his/her ability to learn and adapt to society.

_______ 2. A developmentally disabled person will never have emotional or mental illness.

_______ 3. All developmentally disabled persons need personal contact..

_______ 4. It is important for the N.A. to make all choices for his/her developmentally disabled clients.

_______ 5. It may be difficult to know if a person is borderline developmentally disabled unless testing is done.

In a short essay, discuss 3 probable causes of developmental disabilities.

LESSON PLAN: 13

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. T

2. F

3. T

4. F

5. T

Short essay - (may include any 3 of these ideas)

People whose I.Qs are below 70 are considered developmentally disabled. There are many causes but much is unknown about some of the clients and their problems.

These known causes are:

1. Injury to the brain through head trauma after birth such as a fall which causes a compressed fracture of the skull.

2. Injury to the brain during delivery when oxygen is deprived to the brain either by a compressed cord, cord around neck shutting off trachea and other.

3. Injury to the learning process through physical isolation where a child is not touched or talked to or is consistantly given no more than food and a clean diaper for a prolonged period.

4. Injury to brain before birth due to brain's not growing normally because of mother's use of chemicals.

5. A gene may cause the developmental disability.

6. A growth in the brain can cause brain damage.

LESSON PLAN: 14

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-14 OR DEMONSTRATION:

EMOTIONAL NEEDS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify how the nurse assistant can meet the client's basic physical needs.
2. Identify how the nurse assistant can meet the client's safety needs.
3. Identify how the nurse assistant can meet the client's needs for love.
4. Identify how the nurse assistant can meet the client's need for self-esteem.
5. Identify how the nurse assistant can meet the client's need for self-realization.
6. Describe major losses the client may have experienced.
7. Identify the tasks the elderly must accomplish for successful aging.
8. Recognize ways the client may cope if emotional needs are not met.
9. Identify various nursing approaches to satisfying the emotional needs of the client.

TEACHER RESOURCES:

INTRODUCTION:

Everyone has emotional needs. We must keep in mind that we are not just taking care of the physical needs of the client. Those needs sometimes seem more urgent, but that is not a reason to ignore the emotional needs which include psychological and social needs. A person goes through different stages of life learning to master new tasks so he/she can grow and develop. We will discuss what tasks are required of the elderly person and how he or she can be helped to cope in a positive manner with the aging process.

LESSON PLAN: 14

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

I. Basic Human Needs and How the Nurse Assistant Helps Meet Them (HO 1)

   A. Basic physical needs

      1. Food and fluids - providing adequate diet and fluids

      2. Clothing and shelter - helping to stay warm or cool

      3. Activity and rest - walk with client, ROM, assist to bed, comfortable position

      4. Elimination - able to urinate or defecate

      5. Sexual expression - insure privacy rights

   B. Safety and security needs

      1. Health - good physical health; prevent illness

      2. Protection from injury - side rails, call light close, bed in low position

      3. Ability to help self - promote independence

      4. Own territory or space - allow privacy; client may personalize room with own furniture and personal belongings

   C. Love and belonging needs

      1. Sustaining relationships - encourage visits by friends; allow client to talk about the past

      2. Having someone who cares and to care for - this may be up to the nurse assistant; listen to tales of past, family, experiences; show interest in the client; involve a pet in the facility or home life.

      3. Meeting spiritual needs - assist to religious services

D. Self-esteem

   1. Receiving respect and recognition (sense of identify_ - call client by name; respect privacy

   2. Feeling important - praise client for accomplishments; acknowledge client at all times; respect privacy

E. Self-realization

   1. Satisfying use of time - encourage participation in activities

   2. Having direction - allow him/her to talk about future, feelings about death

   3. Venting feelings without shame - allow him/her to talk

   4. Making decisions - allow client to make any choice possible, may be as simple as what he/she is going to wear today

II. Losses Experienced by the client

A. Loss of health - physical and/or mental

   1. Aging does not always mean illness.

   2. The human body will eventually wear out.

   3. Some behavior may be related to illness; example: client may be irritable and grouchy due to pain.

   4. Sensory system gradually deteriorates which may lead to confusion or withdrawal.

   5. Loss of independence in care leads to poor self-image.

   6. A change in appearance can cause clients to have negative feelings about self.

B. Loss of spouse, family, friends, and pets

   1. Creates a feeling of being all alone and that "no one cares" which can lead to depression

   2. Client may not feel loved if no close family or friends are around to show it

   3. No one around for the client to love

4. No one with whom to have intimate relationships

5. Not able to feel as if needed by anyone

C. Loss of home and job (role in society)

1. Less financial security without a job

2. Less feeling of being needed by society as a resourceful human

3. Miss the "home" environment

4. Loss of independence in maintaining a home and decision-making power

5. Loss of feeling important on the job or able to give to others

III. Tasks the Elderly Must Accomplish for Successful Aging (According to Havighurst*)

A. Learning to live with decreasing physical strength and health

B. Adjusting to retirement and reduced income

C. Adjusting to the death of a spouse

D. Establishing new relationships within own age group

E. Learning to be flexible in social roles

F. Arranging and carrying out satisfactory physical living arrangements

IV. Coping Abilities of the Elderly

A. If a loss in life or sudden illness comes rapidly, it may cause enough stress to make a person unable to cope with all that is happening.

B. Behaviors which may be related to upset emotional status:

1. Client becomes dependent - does not want to take any responsibility for his/her life; poor self-image

*From the Nursing Assistant Training Manual by Fouts and Mullen

2. Client becomes over-suspicious - no longer trusts others; escapes from reality by blaming others for his/her troubles

3. Client is jealous of time you spend with others, wants all of your attention

4. Client becomes depressed due to loneliness, boredom and losses he/she has experienced

5. Client may be angry at prospect of becoming older and more dependent; may be due to all the losses he/she has suffered

6. Client becomes withdrawn possibly due to being very lonely; may withdraw to a world of his/her own where he/she is not considered a "demented senior citizen"

7. Client may become confused/disoriented due to decreased efficiency of sensory system

V. Nursing Approaches

A. Accept the client and his/her personality as is. Try to see the positive things about this person.

B. We may not approve of client's actions, but we let him/her know that we like client for himself/herself.

C. Make client as comfortable as possible--both physically and mentally.

D. The client needs reassurance that he/she is still a functioning adult.

F. Client may need someone to talk to about his/her fears, worries, and anxieties. Be a good listener.

G. Respect client's dignity; never treat an adult as a child. Do not use such words as diapers, bibs, etc.

H. The client has a right to understand what is happening to him/her. Give thorough explanations before a procedure.

I. Never criticize or blame a client for not being able to perform certain tasks.

J. Be pleasant and friendly at all times. Leave your troubles at home so that you can smile often.

K. The client may be very sweet and agreeable to work with or he/she may be irritable, complain about anything and everything, use abusive language, or strike out at you. The client may take out his/her frustrations on the nearest person and it may be you. Accept the client quietly; allow him/her to "sound off."

L. Do not argue with a client.

M. The irritable client is often avoided and neglected by the nurse assistant/ if this is the case he/she will only become more irritable.

N. It is easy to become emotionally involved with your clients. It is easy to love someone who is old, mentally ill or developmentally disabled and needs you! Meet their needs while you are with them. Do the best that you can as you care for them.

O. Due to loss of family or friends, the resident may lack human contact and closeness. Don't forget to smile, squeeze a hand, and give a hug. They need our affection.

VI. Summary and Conclusion

A. Basic human needs and how the nurse assistant helps meet them

B. Losses experienced by the client

C. Tasks the elderly must accomplish for successful aging

D. Coping abilities of the elderly

E. Nursing approaches

Always keep in mind that the older client is an adult with a lifetime of knowledge and experience; draw upon it--allow this adult to continue to thrive, make decisions, and participate in his/her own care. This will enhance self-esteem and feelings of independence. Be alert for clients whose behavior indicates their emotional needs are not being met. Try to help those individuals as best you can. You may refer to the social services designee for assistance in this area.

LESSON PLAN: 14

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. What are basic human needs?
2. How do you think it would feel to grow old?
3. What kind of losses has the resident experienced?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide class into three groups. Assign one or two behaviors listed below. Have students role-play nursing approaches used in each situation.
   A. Dependent client
   B. Overly-suspicious client
   C. Jealous client
   D. Depressed client
   E. Angry-demanding client
   F. Withdrawn client
   G. Confused and disoriented client
2. Ask a client, your grandparents, parents or friends what it is like to grow old.

   Specifically separate memories: school age, teens, working years, family years, middle age and now
3. Pin labels on students' backs, good and bad: i.e. cheat, listener, liar, gossip, shy, etc. Have classmates interact with labels.

LESSON PLAN: 14

COURSE TITLE: NURSE ASSISTANT

UNIT III : UNDERSTANDING THE ELDERLY

EVALUATION ITEMS:

Match the basic human need with the correct way the nurse assistant can help meet that need by writing the letter in the blank.

______ 1.	Basic physical needs	a.	Provide adequate diet and fluids
______ 2.	Love and belonging	b.	Allow client to make choices, encourage activities
______ 3.	Safety and security	c.	Provide side rails, call light
______ 4.	Self actualization	d.	Call client by name, respect privacy
______ 5.	Self-esteem	e.	Encourage family and friends to visit; show a caring attitude

For each of the following, write "T" if the statement is true or "F" if it is false.

______ 6. The elderly person needs to adjust to the physical changes of aging.

______ 7. The elderly person must not accept the death of a spouse.

______ 8. Loss of independence in care can lead to a poor self-image.

______ 9. Since the client is around so many people, he/she always feels he/she is needed and loved.

______10. The elderly client often feels his/her decision-making ability is lost.

______11. It is necessary to give thorough explanations before starting a procedure.

______12. If you do not approve of a client's behavior, let the client know that you do not like her or him and the behavior will improve.

_____13. The client needs reassurance that he or she is still a functioning adult.

_____14. It is appropriate to argue with a client if he/she is wrong.

_____15. Avoid the irritable client so he or she will become less irritable.

16. List three behaviors you may see if the client's needs are not being met.

A.

B.

C.

LESSON PLAN: 14

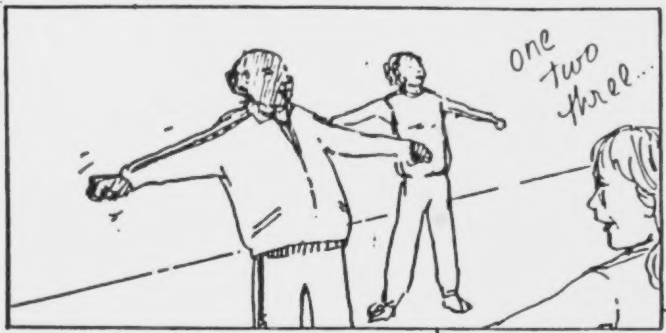
COURSE TITLE: NURSE ASSISTANT

UNIT III : UNDERSTANDING THE ELDERLY

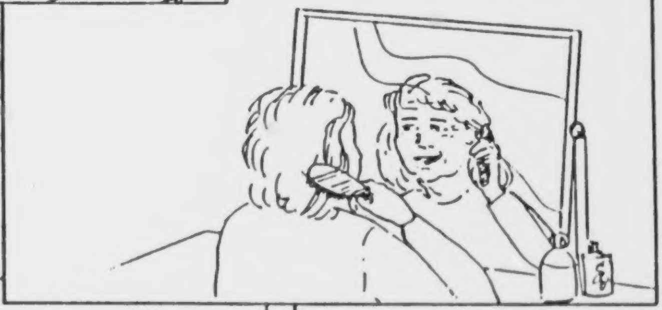
ANSWERS TO EVALUATION ITEMS:

1. a
2. e
3. c
4. b
5. d
6. T
7. F
8. T
9. F
10. T
11. T
12. F
13. T
14. F
15. F
16. The student may list any three of the following:
    a. Dependent
    b. Overy-suspicious
    c. Jealous
    d. Depressed
    e. Angry
    f. Withdrawn
    g. Confused/disoriented

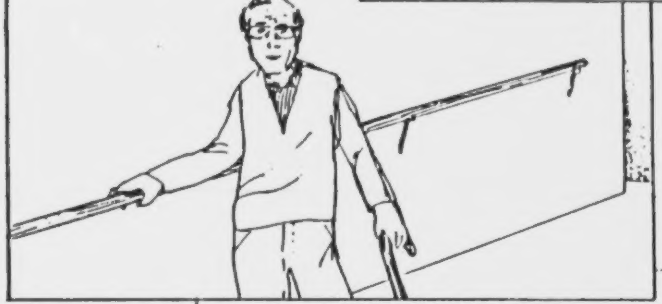
EMOTIONAL NEEDS



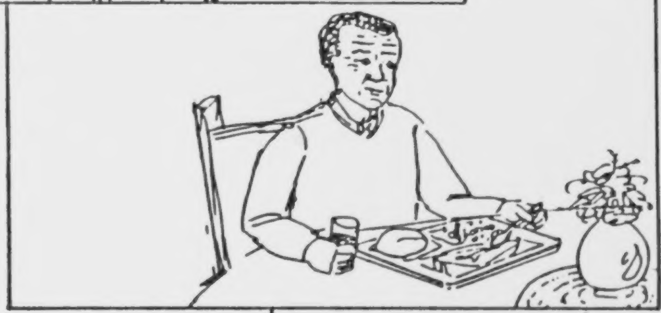
Need to Reach Full Potential



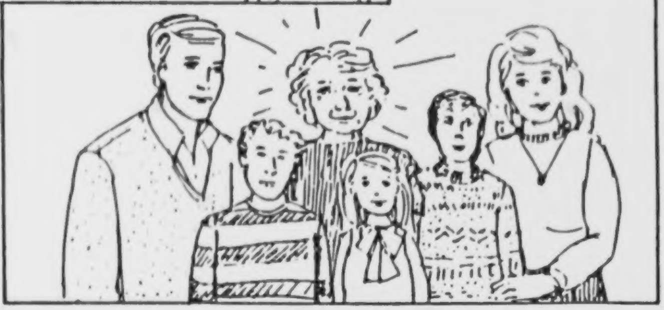
Need for Self-Esteem



Need for Safety



Needs of the Body
(Physical Needs)



Need for Belonging and Love

LESSON PLAN: 15

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-15 OR DEMONSTRATION:

DEALING WITH MENTAL CONFUSION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms introduced in this lesson to correct definitions.
2. Define the term confusion.
3. List two methods of identifying confused clients.
4. List three causes of confusion.
5. List two emotional or physical responses resulting from confusion.
6. List two behavioral responses resulting from confusion.
7. List two functional responses resulting from confusion.
8. Identify correct nursing approaches for the confused client.
9. Identify correct methods of dealing with problem behaviors resulting from confusion.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Understanding Mental Confusion
2. Trainex filmstrip #479: "Start at Confusion"
3. Trainex filmstrip #480: "Turn Toward Identity"

4. Trainex filmstrip #481: "Keep Going Straight"

5. Training filmstrip #482: "Stay in Control"

6. Concept Media filmstrip: "The Stroke Patient," Program III, No. 1, "Language Disorders, Aphasia"

7. Concept Media filmstrip: "Perspectives on Aging," Program IV, "The Confused Person: Approaches to Reorientation"

8. Film Strip Projector

TEACHER RESOURCES:

INTRODUCTION:

Confusion is when one's thoughts are mixed up. Some confusion lasts for a short time because the cause of that type of confusion can be treated. Other confusion is caused by factors that cannot be "cured" which includes Alzheimer's Disease and stroke. Clients' confusion will vary in cause and severity but, in general, they are confused in some way every day.

LESSON PLAN: 15

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

Outline: (Key Points)

I. Terms and Definitions

A. Acute - developing rapidly with pronounced symptoms and lasting a short time*

B. Agnosia - loss of the ability to recognize familiar objects through any of the senses

C. Aphasia - loss of the ability to use or understand language*

D. Apraxia - loss of the ability to carry out planned movement at will

E. Catastrophic reaction - overreaction to circumstances

F. Chronic - continuing over a long period of time or recurring frequently; chronic conditions begin insidiously and symptoms are not as noticeable as in acute conditions*

G. Confused - Mental state of disorientation to time, person, place

H. Dehydration - loss of body's normal water content which can affect both physical and mental functions

I. Dementia - severe impairment of cognitive functions such as thinking, memory, and personality*

J. Disorientation - the state of mental confusion or loss of bearings in relation to the sense of person, place or time

K. Hallucination - sensory perceptions that seem real to the person experiencing them but are not perceived by others

L. Paranoia - suspiciousness inappropriate to reality

* (From AGE WORDS: A Glossary on Health and Aging, NIH Publication #86-1849, January, 1986.)

M. Sundowning - phenomena when behavior problems become worse in evening

N. Wandering - aimless walking which may result in a resident becoming lost

II. Confusion (HO 1)

A. Definition

1. Acute confusion

2. Chronic Confusion

B. Identification of those who are confused and why

1. Observation

2. Appropriate use of the reality orientation questionnaire

III. Causes of Confusion

A. Physical factors

1. Disease of the central nervous system (brain)

(a) Senile dementia of the Alzheimer type

(b) Stroke

(c) Brain damage

2. Lack of oxygen to the brain

3. Fluid, electrolyte and nutrition difficulties (dehydration)

4. Undetected infections (temperature elevation)

5. Elimination difficulties (constipation)

6. Effects of medication

B. Sensory/emotional factors

1. Lack of stimulation or overstimulation (sensory overload)

2. Misinterpretation of sensory input (either poor vision, hearing, or dementia--aphasis, agnosia)

3. Depression
4. Hallucinations, delusions

C. Environmental factors

1. New surroundings (adjustment)
2. Isolation (decreased contact with other than confused people)
3. Restraints
4. Misinterpretation of the environment

IV. Effects of Confusion on Activities of Daily Living

A. Emotional or physical responses

1. Being suspicious
2. Being rude, angry, insulting
3. Being constantly restless or talkative
4. Seeing things not there (visual hallucination)
5. Hearing voices from past (auditory hallucination)
6. Reliving situations from past
7. Not responding to anything

B. Behavioral responses

1. Having difficulty remembering how to do simple tasks or not finishing things started
2. Forgetting what day it is, what time of life, who client is
3. Losing, hiding, or misplacing things and looking all over for them
4. Wandering or getting lost

C. Functional responses

1. Unable to dress self
2. Unable to feed self
3. Unable to bathe, shower or shave self

    4. Incontinent of bowel or bladder

V. Nursing Approaches

- A. Caregiving environment
    1. Treat client with dignity and respect.
    2. Know the client as an individual (his/her past, likes, and dislikes).
    3. Always introduce yourself, call the client by name and explain what you are doing when you approach the client.
    4. Create a calm, orderly routine.
    5. Familiarize clients to surroundings as often as necessary.
    6. Provide mechanical aids as needed by client (hearing aids, glasses).
    7. Provide sensory stimulation
        a. Conversation
        b. Music
        c. Touch
        d. Group activity
- B. Observe physical needs to maintain resident's health.
    1. Observe and report changes in thinking or memory.
    2. Monitor nutritional and fluid intake.
    3. Observe signs of infection besides an elevated temperature and report.
- C. Use appropriate measures to maintain function.
    1. Orient to appropriate holidays or activities related to the facility, home or client's life.
    2. Conversation should include current interactions as well as those from past history.
    3. Place familiar personal articles in room.
    4. Encourage client's participation in activities outside his/her room.

5. Encourage visits, telephone calls, letters from family, friends, visitors, other clients.

6. Assist client to maintain appearance that he/she can be proud of.

7. Respond to feelings, display empathy, interest.

VI. Problem Behaviors Resulting from Confusion

A. Catastrophic - overreaction, paranoia, sundowning, inappropriate sexual behavior, etc.

B. Suggestion for coping with these behaviors.

1. Identify exactly the behavior to be examined or altered, separate from attitude.

2. Try to determine the cause of the behavior.

3. Plan and discuss ways to handle and react to the behavior with others involved in the resident's care.

VII. Summary and Conclusion

A. Terms and definitions

B. Confusion

C. Causes of confusion

D. Effects of confusion on activities of daily living

E. Problematic behaviors resulting from confusion

A confused state of mind may be very frightening and upsetting to both the client and the caregiver. Sometimes caring for the confused person is difficult and frustrating because a "cure" is not always possible, and they can't or won't say "thank you" for your work. Although they are as vulnerable as children, they are not children and should not be treated in that way. Your care can make the difference between good days and bad days. Your victories may come in small measure--shared awareness in the moment between you and a confused client--but recognize them as very important achievements and feel proud.

LESSON PLAN: 15

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. What may cause a client to become confused?
2. How could elimination difficulties cause confusion?
3. In what ways could a client misinterpret his/her environment?
4. Why is it important to maintain a calm, orderly routine?
5. Why should you encourage communication with others?
6. Why is it necessary to agree on a plan of action for dealing with problematic behavior?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students break into groups of four or five and role-play interactions between a confused client and memers of the health care team.
2. View filmstrips.

LESSON PLAN: 15

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

______1. Agnosia

______2. Aphasia

______3. Apraxia

______4. Catastrophic reaction

______5. Dementia

______6. Paranoia

______7. Sundowning

a. Worsening of behavior problems occurs in the p.m.

b. Severe impairment of cognitive functions

c. Suspiciousness inappropriate to reality

d. Loss of ability to recognize familiar objects

e. Overreaction to circumstances

f. Loss of ability to use or understand language

g. Loss of ability to carry out planned movement at will

8. What is confusion?

9. What are two methods of identifying confused clients?

   a.

   b.

   c.

10. List three major causes of confusion in long-term care clients.

   a.

   b.

   c.

11. List two emotional or physical responses that may result from confusion.

    a.

    b.

12. List two behavioral responses that may result from confusion.

    a.

    b.

13. List two functional responses that may result from confusion.

    a.

    b.

For each of the following, write "T" if the statement is true, or "F" if it is false.

____14. If you treat the client like a child he/she will be happier.

____15. It is important to create a calm, orderly routine for the confused client.

____16. The confused client should not be provided with his/her hearing aid or glasses as he/she may lose them.

____17. The physical needs of the confused client should be monitored to maximize his/her health.

____18. The confused client should not be encouraged to participate in activities outside his/her room since it may be upsetting for him/her to be in contact with other clients.

____19. Never talk about the past with the confused client.

____20. When dealing with problem behaviors of the confused client it is important to coordinate handling of and reaction to the behavior with others involved in the client's care

LESSON PLAN: 15

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. d
2. f
3. g
4. e
5. b
6. c
7. a

8. Confusion is a state disorientation to time, person, place.

9. a. Observation
   b. Appropriate use of the reality orientation questionnaire

10. a. Physical factors
    b. Sensory/emotional factors
    c. Environmental factors

11. The student may list any two of the following:
    a. Being suspicious
    b. Being rude, angry, insulting
    c. Being constantly restless or talkative
    d. Seeing things not there (visual hallucination)
    e. Hearing voices from past (auditory hallucination)
    f. Reliving situations from past
    g. Not responding to anything

12. The student may list any two of the following:
    a. Having difficulty remembering how to do simple tasks or not finishing things started
    b. Forgetting what day it is, what time of life, who you are
    c. Losing, hiding, or misplacing things and looking all over for them
    d. Wandering or getting lost

13. The student may list any two of the following:
    a. Unable to dress self
    b. Unable to feed self
    c. Unable to bathe, shower or shave self
    d. Incontinent of bowel or bladder

14. F
15. T
16. F
17. T
18. F
19. F
20. T

UNDERSTANDING MENTAL CONFUSION

About half of the long-term care population consists of clients who are confused, so it is important for nursing assistants to understand confusion and how to care for these clients. Although cause of confusion is important, the state of confusion looks different among individuals depending on what ability to think is deficient: i.e. memory of recent events, well-learned skills, long ago memories; loss of orientation to person, place, time; language disturbance; visual and motor problems; problem solving and judgement.

EXAMPLES: Memory--the ability to recall something that just happened may be lost but memories of childhood may be intact. Another category of memory has to do with well-learned tasks like driving, writing, dressing, and toileting. It is possible to lose just the ability to sequence the steps of an activity or the entire skill. Giving a verbal cue or demonstrating is helpful. Music is a memory that may remain intact when other skills are lost.

Orientation--to person, place and time may be lost selectively or altogether. A client may not recognize which room is his/hers but could recognize a roommate or nurse.

Language disturbance (aphasia) -- has two forms. It may be possible to produce speech and talk, but not understand what someone is saying or impossible to speak, yet can understand what is said.

Visual problems (agnosia) -- when someone sees but can't figure out what the object is.

Motor problems (apraxia) -- when someone wants to move as in picking up a spoon but just can't seem to do that.

The client who experiences loss tries to compensate, may become emotionally upset, or become very frightened. There is a hierarchy of functions of the brain that is important to consider, for as the highest level becomes impaired, an individual may depend more on other levels of function. The simplest level is the autonomic function like breathing or the heartbeat of which we are hardly aware. The next level is sensory awareness as in seeing, hearing, touching, hunger, elimination, and orientation to sex. Higher up the complexity scale are instinctive behaviors which are genetically encoded like caring for others, self-defense, fear, finding shelter, etc. The most sophisticated level is abstraction and thinking which is the ability that is the most noticeable and the first to be disturbed in confused clients. As clear thinking is lost, they will depend to greater degree on the other levels of function.

It is important for the nurse assistant to realize that the client may feel threatened and not understand what is happening in his/her environment. The nurse assistant can communicate concern, acceptance, and reassurance. This can be done both verbally and nonverbally (facial expression, eye contact, body language, touch, tone of voice, etc.). The confused person often responds to the nonverbal communication as memory and language fail. There are nursing care measures that will help to minimize the effects of confusion. The nursing goal is to maintain the client at the highest possible functional level for the longest amount of time.

LESSON PLAN: 16

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-16 OR DEMONSTRATION:

ACTIVITIES IN THE LONG-TERM CARE FACILITY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the term diversionary.
2. Describe four types of activities.
3. Identify responsibilities of the nurse assistant in client activities.
4. Recognize ways the nurse assistant may participate in the activity program for the client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

TEACHER RESOURCES:

INTRODUCTION:

In many long-term facilities there is an activities director for planning and carrying out parties, games, discussion groups, and other social activities. This is not always the case. The nurse assistant may be responsible for working with or carrying out some of the duties of an activities director if one is not available. It is important for the client to be around people; they need to be kept interest and active in some way. The following lesson plan will identify types of activities, the responsibilities of the nurse assistant and how he/she may assist the client.

ESSON PLAN: 16

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

I. Types of Activities
  A. Quiet time activities
    1. Privacy from other clients and staff
    2. Reading
    3. Talking with others; i.e., clergy, social services, friends, family
    4. Sitting with clients - remember the importance of listening and touching
    5. Correspondence - assist by writing letters for the resident or reading mail to client
  B. Therapeutic
    1. For rehabilitation purposes - group exercise
    2. To continue functioning in ADL
  C. Diversionary
    1. Definition - to draw attention to something else or to amuse
    2. For mental stimulation
    3. For social contact
      a. Improve personal grooming
        (1) Facial grooming
        (2) New hairstyle
        (3) New clothing
        (4) Manicure
      b. Audiovisual
        (1) Television

(2) Radio

(3) Movies

(4) Records or tapes

(5) "Talking books" or music

c. Games

d. Handicraft

e. Relaxation exercises

D. Programing needs of clients with mental disorders

1. a. ADL

b. Work habits

c. Socialization activities

d. Handwork and simple crafts

e. Housekeeping of own unit

f. Physical exercises

g. Reinforce behavior modification goals.

2. Severe mentally ill and developmentally disabled

a. Direct in range-of-motion exercises.

b. Encourage crawling.

c. Encourage music therapy.

(1) Rhythm band

(2) March or clap to music

(3) Listen to music

d. Allow client to hold soft stuffed toys

e. Hang bright mobile overhead.

f. Place bed near window or hold client in lap so she/he can see the outdoors.

    g. Point out objects.

    h. Decorate rooms.

11. Nurse Assistant's Responsibilities

    A. Suggest activities of interest to the client in a positive, enthusiastic way.

    B. Check activity calendar daily and plan care accordingly.

    C. See that the client is clean and properly dressed before sending him/her to activity.

    D. See that the client goes or is taken to the proper place at the right time.

    E. See that the client returns to his/her bedroom after an activity. Do not leave the client sitting without a means of calling for help.

    F. Confer with activities director regarding things to do and equipment availability.

    G. The nurse assistant must develop an attitude of support and encouragement to the activity program.

    H. Encourage clients to think about activities they would like to do and suggest them to the activities director.

III. Nurse Assistant's Participation

    A. When daily care routines are complete or you have some extra time, offer to do some activities.

        1. Play checkers with a client.

        2. Play cards with one or several clients.

        3. Read to a client.

        4. Encourage clients to listen to news on the radio or watch television and discuss with them.

        5. Write a letter for client.

    B. After supper, encourage some kind of activity to delay bedtime until 8:30 or 9:00 p.m.

        1. Hold a checker tournament.

    2. Bowling (can be done from a w/c).
    3. Encourage visiting each other.
    4. Encourage watching television.
    5. Encourage individual crafts.

C. During the night, if the client has trouble sleeping, sit and talk with him/her a few minutes; offer a backrub.

IV. Summary and Conclusion

A. Types of activities

B. Nurse assistant's responsibilities

C. Nurse assistant's participation

Days without meaning are useless. Long-term care clients need something to look forward to each day. You can bring this spark of anticipation to their lives.

LESSON PLAN: 16

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. Discuss the suggested types of activities and how each helps to reduce stress and benefit the client.
2. Discuss specific activity programs available or offered at the facility where the nurse assistant is employed.

CLASSROOM, LABORATORY, OR OTHER ACTIVITIRS

LESSON PLAN: 16

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

1. Define the term diversionary.

2. Briefly describe the four types of activities:
    a. Quiet time activities
    b. Therapeutic
    c. Diversionary
    d. Programing needs of clients with mental disorders

3. Which of the following is not a responsibility of the nurse assistant? (Circle the letter of the correct answer.)
    a. Check activity calendar daily.
    b. Plan and direct all activities of the home.
    c. See that the client goes to the activity.
    d. See that the client is clean and properly dressed.

4. The nurse assistant can participate in the activity program by: (Circle the letter of the correct answer.)
    a. Play checkers with the client when daily care is completed
    b. After supper encourage client to watch T.T. or visit with another client.
    c. During the night offer a backrub and talk with a client who is having difficulty sleeping.
    d. All of the above

LESSON PLAN: 16

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. To draw attention to something else or to amuse

2. a. Includes quiet activities such as reading, talking, communicating with the client--not a planned or group activity

   b. For rehabilitative purposes such as exercise class

   c. Activities that are for mental stimulation and provide a time for socialization with other clients.

   d. Activities for clients with mental disorders depends upon type of disorder; for those with moderate disorders, recommended activities are things such as learning work habits, crafts, basic housekeeping, and physical exercise. For more severe mental disorders use music, provide bright objects to look at, and encourage the client to use touch.

3. b

4. d

LESSON PLAN: 17

COURSE TITLE: NURSE ASSISTANT

UNIT III **:** THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-17 OR **DEMONSTRATION:**

LIFE CYCLE I
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify 3 different age groups
2. Name a physical, psychological and social characteristic for each age group within this lesson.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

TEACHER REFERENCES:

INTRODUCTION:

This lesson will tell you briefly about how human beings grow and develop physically, psychologically and socially from birth up to the middle adult but not including the older adult.

A brief discussion of the common diseases and conditions of illness for each age group will be included in this lesson as well as some things you, as a nurse assistant, can do when assigned to a client.

Remember that growth and development occur from when the egg and sperm meet to death, that it proceeds from simple to complex, from head to foot in an ordered sequence and pattern and is uneven with rapid and slow periods.

LESSON PLAN: 17

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

A. Terms and definitions:

1. Age groups (this is only one of many ways to separate and name age groups)

   a. Newborn
      1-30 days

   b. Infant
      1-18 months

   c. Toddler/Preschooler
      1 1/2-6 years

   d. Childhood/Schoolage
      6-12 years

   e. Adolescent
      12-18 years

   f. Young adult
      18-25 years

   g. Adult
      25-45 years

   h. Middle adult
      45-65 years

   i. Older adult
      65-75 years

   j. Elderly adult
      75 years +

2. Physical - pertaining to the body and its function

3. Psychological - pertaining to behavior, functions and processes of the mind

4. Social - living according to standards and expectations of a group or community

5. Diseases or conditions of illness - disorder of vital function involving any structure, part or system of an organism

6. Growth - change in a person that can be measured and occurs in a steady, orderly manner.

7. Development - changes in a person's psychological and social functioning

B. Following will be SOME characteristics of each age group:

1. Newborn:

   a. Physical: 7 pounds and 20 inches, gains 6 ounces each week, head 1/4 of body length, sees brightness, responds to sound, taste and smell

b. Psychological: everyone accepts newborn, startles sucks instinctively, develops along spinal cord, head to feet, loves to be cuddled, must TRUST caregiver.

c. Social: can sleep 20 hours a day, everyone accepts newborn, concentrates on faces.

d. Diseases or conditions of illness: anoxia, congenital defect (cleft lip), colic, birth injury, jaundice, hyaline membrane

e. Nurse assistant should: observe feeding, arm and leg movements, reaction to light and sound, sleeping pattern, keep newborn clean and dry

2. Infant

a. Physical - birth weight doubles by 5 months, deciduous teeth appear 5-7 months, can be 30 inches at 12 months, fontanels are closed by 18 months, far vision well developed, may start bowel/bladder training, turns over, crawls, pulls self up, etc. in sequence

b. Psychological - short attention span, cries for attention, needs constant care, shows emotion such as anger, affection, speech starts, recognizes caregiver's face at 5 weeks with smile.

c. Social - needs to be touched, people like infants, fears strangers, plays better alone

d. Diseases or conditions of illness - colds, rashes, chicken pox, diarrheas

e. Nurse assistant should - offer comfort measures for teething, keep infant clean and dry, provide stimulation of all senses, observe for safe conditions.

3. Toddler/pre-school child

a. Physical - bowel then bladder training should be complete near 3 years, uses large muscles first, head doubles in size, first permanent tooth in by 6 years, can be 50 inches tall and 50 pounds by 6 years.

b. Psychological - imitates adults in play, curious, imaginative, contrary, bossy, attention span lengthens, afraid of dark, fire engines, interested in numbers near 6 years.

c. Social - dependent on caregiver, no male/female discrimination in play, correct behavior with "what you did was naughty" NOT "you are a naughty girl", boy needs male model , girl needs female model , learns to listen to directions, nursery school develops sociability, can be given small responsibilities, conscience develops at end of this age group.

d. Diseases or conditions of illness - chicken pox, diarrheas, colds, ear, throat and nose infections, accidents, worms.

e. Nurse assistant should - protect and observe to prevent accidents in home and community, keep food and hands of child clean, assist brushing teeth, assist with toileting, keep child neat and clean, offer opportunities to play quietly and with others.

4. Childhood/school age

a. Physical - energetic, skin now "tough", steady growth with more rapid growth 9-12 years for girls, can be 45-60 inches and 50-95 pounds by 12 years, well coordinated by 12 years, jaw enlarges to accommodate all permanent teeth by 12 years, clear speech develops, left or right handedness, eyes finish growing by 9 years, leukorrhea may be first sign of impending menstruation

b. Psychological - develops ego, must meet success at school, play and home, imitates adults, uses imagination, uses intelligence to banish fears, cautious, special talents discovered by 11-12 years, sexual interests start

c. Social - plays in groups, clubs, games with rules, special friends, can get along with others, can be "wise guy"

d. Diseases or conditions of illness - stomach aches, allergies, vision and hearing problems, chicken pox, colds, accidents, lice

e. Nurse assistant should - stimulate client with games and talk, let friends be with client, listen to complaints, inspect for lice, remind of grooming.

5. Adolescent

   a. Physical - rapid growth-girls finish near 16 years, boys almost finished by 18 years, menstruation should begin by 16 years, nocturnal emissions of semen, secondary sex characteristics develop, can become parents

      Some secondary sex characteristics in girls are: increase in breast size, appearance of axillary and pubic hair, deeper voice, widening and rounding of hips, oily skin and hair

      Some secondary sex characteristics in boys are: penis and scrotum slowly enlarge from late childhood, appearance of axillary, pubic, body and facial hair, shoulders widen, neck thickens, oily skin and hair

   b. Psychological - little sense of responsibility for sexual impulses, thinks of future, reasons logically, prepares for career, accepts responsibilities at home, school and work, normal to have wide swings in emotional reactions to changes, must be good at something, day dreams, ego-centric, self-identity established, reexamines value systems

   c. Social - needs mono-sex groups and bi-sex groups, peers are important, cliques, moves from family to friends, intense relationships, experimenting with life, moving from dependence to independence, needs privacy, family difficulties, needs adult to listen

   d. Diseases or conditions of illness - start of auditory nerve deafness, neuroses, substance abuse and addiction, depression, accidents, occupational hazards

   e. Nurse assistant should - be a good listener, provide good food, encourage client to care for self

6. Young adult

   a. Physical - females finished growth and development, males may continue through 25 years, last bone at base of skull is fused by 21 years, skin less oily

b. Psychological - formal education completed, responsibilities of life assumed, sex identity established by 18 years, establishes intimate relationships, deepening interests in art, music, etc., cares for others, thinks abstractly, increases distance from parents, uses "things" to get attention

c. Social - away from home-school, apartment, own home, likes parties, travel, new friends become life-long friends, sees parents now as individuals

d. Diseases and conditions of illness - substance abuse and addiction, depression, other psychological illnesses, venereal diseases including AIDS, accidents, mononucleosis, acquired diseases start like: hypertension, heart disease, cancer, etc.

e. Nurse assistant should - be a good listener, observe for signs of abnormal behavior, physical illness, respect privacy and independence

7. Adult

a. Physical - skin smooth, hair less oily, body and bones in good proportion - head 1/7 of height, prime age for child bearing and rearing, starts to gain weight, may start hearing loss

b. Psychological - patient, good listener, settles down in own home, gets along with others, copes with life's problems, needs companionship in work, neighborhood, recreation, distance from parents increases, good sexual relationships, questions direction of life near 40 years, may make changes in career

c. Social - many friends, accepted by people, family orientation slowly moves to outside family orientation, career important, money important, may care for parents as well as children, divorce, remarriage

d. Diseases and conditions of illness - diabetes, substance abuse and addiction, degenerative diseases start (heart and circulation, joint, lung) obesity, headaches (migraine), psoriasis, AIDS.

e. Nurse assistant should - check vital signs, encourage good health habits, observe for signs of illness

7. Middle Adult

   a. Physical - wrinkles in sun-exposed skin, hair turns grey, menopause, hearing loss, hyperopia, weight gain, joint stiffness, tooth and gum problems, less sex hormones, body shortens due to calcium loss and muscle shortening

   b. Psychological - brain cells die, less patience and energy, fears signs of aging, worries about death, is a new age historically, have many roles in life, any crisis begins a decline (occupation, death of spouse, poor health), sleep disturbances, boredom

   c. Social - more free time, takes up interests and hobbies, family main interest, needs friends, volunteers, enjoys freedom, can be parents and grandparents of young child

   d. Diseases and conditions of illness - (medicine cabinet tells all) arthritis, diabetes, hypertension, heart and lung disease, obesity, degenerative disorders, cancer of any organ, oral problems, accidents

   e. Nurse assistant should - observe for signs of illness, check vital signs, encourage good health habits, keep environment safe and comfortable.

65 years and older is discussed in the next lesson

Summary and Conclusions:

1. Terms and definitions

2. Age groups with some of physical, psychological and social characteristics, diseases and conditions of illness and nurse assistant's role

You have learned that a human being grows and develops rapidly in the early years, that each person must be prepared for life as a contributing member of society and that the body slows down during the later years. This is a time of more freedom and enjoyment of travel and hobbies. It is important to grow older having a healthy body, a sound mind and to be surrounded by friends and family.

LESSON PLAN: 17

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. When do you think one is at his/her prime in life?
2. Why is it important for a nurse assistant to know about changes that occur in adolescence?
3. When is the period of most rapid growth and development?
4. What can a nurse assistant do to prevent accidents for the various age groups?
5. When is most intellectual development occurring?
6. When does a person start leaving the family for a life of his/her own?
7. When is the best time for child bearing and rearing?
8. During which age group do most physical difficulties start?

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Discuss with students their feelings about becoming adults.
2. Have students discuss responsibilities they have now in life.

LESSON PLAN: 17

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______1. The average weight and height of a newborn is 7 inches and 20 pounds.

_______2. Newborns and adults do not have the same body proportions.

_______3. The newborn's first tooth appears sometime after 5 months.

_______4. An adolescent's hormones make major changes in the body such as body hair and menstruation.

_______5. An adolescent rarely has disagreements with his/her parents or guardians.

_______6. The nurse assistant must be a good listener to an adolescent.

_______7. Sex identity solidifies at the start of young adulthood.

_______8. Venereal disease and degenerative diseases are most common during young adulthood.

_______9. It is important that the adult settles down in a career and home life.

_______10. The adult often has responsibilities for his/her own family and his/her parents.

_______11. The middle adult can have responsibilities for own young children, grandchildren and own parents.

_______12. The middle adult can enjoy freedom to travel and pursue hobbies.

Give appropriate ages for the following names of age groups:

_______13. Newborn

_______14. Infant

_______15. Toddler/preschool child

_______16. Childhood/school-age child

_______17. Adolescent

_______18. Young adult

_______19. Adult

_______20. Middle adult

_______21. Older adult

22. Define Growth

23. Define Development

LESSON PLAN: 17

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. F
2. T
3. T
4. T
5. F
6. T
7. T
8. F
9. T
10. T
11. T
12. T
13. 1-30 days
14. 1-18 months
15. 1 1/2-6 years
16. 6-12 years
17. 12-18 years
18. 18-25 years
19. 25-45 years
20. 45-65 years
21. 65-75 years
22. Growth is changes in a person that can be measured
23. Development is changes in a person's psychological and social functioning

LESSON PLAN: 18

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-18 OR DEMONSTRATION:

LIFE CYCLE II
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify one physical sign of aging from each body system.
3. Match health problems to appropriate definitions.
4. Identify nursing measures to help the aging client with certain health problems.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Aging Process: Nursing Care Points to Remember
2. Trainex filmstrip #453: "Physiology of Aging: Physical Appearance and Special Senses"
3. Trainex filmstrip #454: "Physiology of Aging: Changes in Function and Capacity"
4. Concept Media filmstrip: Perspectives on Aging, Program II, "Physical Changes and Their Implications"
5. Projector
6. Chalk and blackboard
7. Skeletorso

TEACHER RESOURCES:

INTRODUCTION:

Each day we grow older. There are many theories as to why the aging process occurs, but they are only theories. Maybe if we knew the reason for the aging process, some of the physical signs could be slowed down. The nurse assistant needs to be aware of what changes take place as the body ages; some of these changes are obvious; some occur inside the body and are not visible, yet can influence the way you care for the elderly client. The nurse assistant also needs a basic knowledge of common health problems, the related signs of the illness to be observed, and the basic nursing care that follows.

LESSON PLAN: 18

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Atrophy - decrease in size; waste away

   B. Contracture - when muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily - Example: footdrop

   C. Expectorate - coughing up matter from respiratory tract and spitting it out

   D. Purulent - containing pus

   E. Sputum - waste material coughed up from lungs or trachea

II. Musculoskeletal System (HO 1) CD-1

   A. Aging process

      1. Muscular weakness - muscles gradually wear out; may atrophy due to disuse from inactivity--leads to contractures

      2. Bones become lighter and more brittle

      3. Stiffening of joints

      4. Slumped posture due to deterioration of spine

   B. Related health problems

      1. Fracture - broken bone

         a. Signs - pain, swelling, bruising, deformity and possible shortening, loss of movement

         b. Nursing care - do not move client, stay with client; notify charge nurse or H.H.A. supervisor.

2. Arthritis - inflammation of a joint, any joint can be affected

a. Signs - pain, redness, swelling in joint area, stiffness, may progress and cause deformity of joint

(1) Nursing care - rest, exercise programs, heat; no known cure

3. Cancer - growth of abnormal cells into a tumor which alters the normal functioning of body tissues; can occur anywhere in the body

a. Signs - depend upon where it is located; but general signs include unexplained weight loss, unusual bleeding, a lump or sore that will not heal, change in wart or mole, difficulty swallowing, change in bowel or bladder habits

(1) Nursing care - if any of above signs noted, report to charge nurse or H.H.A. supervisor; client needs good nutrition, skin care, hygiene, emotional support; some forms of cancer are curable

III. Nervous System

A. Aging process CD-2

1. Normal aging causes some shrinkage of the brain, but:

a. Only mild forgetfulness, no gross confusion

b. Only mild slowing of movement, no major loss of balance

c. Only mild impairment of sight and hearing

d. Only mild changes in urinary function

2. Major difficulty in any of the above functions is the result of disease, not normal aging

B. Nervous system disorders in the elderly

1. Major mental deterioration (organic brain syndrome) - serious loss of memory, confusion, poor judgment, impaired ability to care for one's self (because of loss of thinking ability), personality change; many possible causes, some reversible (such as effects of certain drugs, toxic chemicals, thyroid deficiency, malnutrition), some irreversible (such as Alzheimer's disease, which is a disease of brain cells)

a. Delirium (acute brain syndrome) - fluctuating confusion, often with periods of drowsiness; often reversible by removing offending drugs, or by treating the underlying cause, such as pneumonia, urinary infection or altered blood chemistry

b. Dementia (chronic brain syndrome) - more likely to worsen progressively; usually irreversible, but occasionally a reversible or curable problem is found, such as thyroid deficiency; depression in an older person can mimic dementia; Alzheimer's disease is the commonest cause of dementia in the elderly (AD is not due to loss of oxygen or "hardening of the arteries")

1. Nursing care - safety measures, be patient and understanding, treat patient as a person, supply social and emotional support; remember his/her changed behavior is the result of a disease process

2. Stroke (CVA, cerebrovascular accident, loss of O2 to brain cells) caused by sudden damage to brain either through hemorrhage from an artery in the brain or by loss of blood supply when an artery bringing oxygen to the brain is blocked.

a. Symptoms and signs may be transient, (TIA's) (lasting for only a short period of time) or long-lasting and sometimes permanent; they include: dizziness, headache, slurred speech which may not be understandable, weakness in arm and/or leg on one side, difficulty swallowing, incontinence of urine or stool, loss of vision, memory loss, and confusion

1. Nursing care - good hygiene and skin care, assist with ROM exercises, B&B retraining, emotional support, safety precautions, help with nourishment

3. Spinal cord injuries - damage to spinal cord resulting in paralysis, often permanent

a. Paraplegia - paralysis of legs

b. Quadraplegia - paralysis of arms and legs

c. Signs - limbs paralyzed depend on level of injury, breathing sometimes impaired; bladder and bowel often paralyzed (retention or incontinence)

    1. Nursing care - good hygiene, ROM, position changes, B&B retraining, teach how to transfer, emotional support

4. Parkinson's disease - a disease of the brain cells which control movement; often responds well to drug treatment in first several years; signs include slow, short steps, shuffling, tendency to fall, stooped posture, tremor of hands; mental function often normal but sometimes impaired; confusion may result from drugs used to treat the Parkinsonism

5. Multiple sclerosis - a disease which causes degeneration in the brain, spinal cord and nerves

   a. Signs - paralysis of legs and arms, numbness, incontinence, blindness, deafness, speech and mental problems

      1. Nursing care - safety measures, skin care B&B training, exercise program; no known cure

III. Sensory System (CO-3)

A. Aging process

1. Decline in smell and taste
2. Difficulty in distinguishing colors, increased light requirements
3. Eyes adjust more slowly to light changes
4. Dryness of eye (decrease in tears)
5. Peripheral vision narrowed
6. Progressive hearing loss of high pitched sounds
7. Decreased perception of pain, heat, and cold by touch
8. Decreased finger dexterity
9. Decreased reaction time

B. Related health problems

1. Blindness - inability to see

2. Cataracts - lens becomes cloudy

3. Glaucoma - increased pressure within eyeball causing blindness if untreated

4. Deafness - inability to hear

   1. Nursing care - adequate lighting, safety measures, encourage client to wear corrective aids, season food as tolerated and as physician has ordered, check temperature of anything before applying to client

V. Cardiovascular System (CD-4)

A. Aging process

1. Arteriosclerosis - blood vessels, especially arteries, harden and thicken, lose elasticity

2. Atherosclerosis - fat deposits inside arteries make arteries narrower

3. Congestive Heart Failure - decreased amount of blood pumped. Pumping efficiency of heart less effective, edema may occur

4. Orthostatic hypotension - inability of cardiovascular system to adjust quickly enough to position changes; may cause dizziness and lead to fainting

B. Related health problems

1. Hypertension - due to narrow and less elastic arteries, heart has to pump with greater force causing BP to rise

   a. Signs - systolic pressure consistently over 160 or diastolic pressure over 100

      1. Nursing care - monitor BP as ordered

2. Heart attack - due to arterial walls being narrow and rough, clots are likely to form. If a clot blocks an artery of the heart, those cells beyond the blockage will die.

a. Signs - chest pressure or pain, change in pulse rate and rhythm, pain in left arm or jaw, decreased BP, perspiration, change in respiration
NOTE: The elderly do not always experience "chest pain," they may suffer a heart attack and not even know it.

   1. Nursing care - report to charge nurse immediately of any of the above signs

3. Congestive heart failure (CHF) - heart is unable to pump adequate amount of blood

   a. Signs - change in pulse and respiratory rate and rhythm, change in sound of respirations, shortness of breath, edema of lower extremities

      1. Nursing care - restrict fluid intake, observe for and report any of the above signs

4. Pacemaker

   a. A mechanical device to stimulate the heart to beat properly

      1. Nursing care - know the set heart rate and report to charge nurse or H.H.A. Supervisor if it falls below that rate; report shortness of breath, edema, irregular pulse rate, or dizziness to charge nurse or H.H.A. Supervisor; report any skin discoloration or pain at pacemaker site; electrical wires of the pacemaker could be out of place if the client hiccoughs--notify charge nurse or H.H.A. Supervisor.

VI. Respiratory System (CD-5)

A. Aging process

   1. Lungs do not expand and contract as well, therefore, must breathe harder and longer

   2. Shallow breathing due to chest muscle weakness

   3. Cough not as effective due to muscle weakness

B. Related health problems

   1. Emphysema - elasticity of alveoli in lungs is lost, making it more difficult to breathe; air gets in but is hard to get out of lungs; leads to lack of oxygen in blood, difficulty breathing and heart problems

a. Signs - shortness of breath, dyspnea, increased size of chest, pursing of lips (helps get air out)

1. Nursing care - avoid fatigue; give breathing exercises; force fluids to keep secretions liquid and easier to expectorate; remember safety precautions when O2 is in use

2. Pneumonia - an inflammation of the lung, fluid accumulates in alveoli of affected area

a. Signs - chills, fever, chest pain, purulent sputum

1. Nursing care - bedrest, comfort measures, needs medical Rx, proper nutrition

VII. Digestive System (CD-6)

A. Aging process

1. Loss of teeth, results in less proper food consumption; diet consistency may need to be changed.

2. Do not need as many calories, but need same nutrients.

3. Slower movement of food in intestine due to poor muscle tone; can cause constipation

4. Excessive intestinal gas due to #3

B. Related health problems

1. Diarrhea - frequent passage of watery stool (BM)

a. Nursing care - report number and characteristics of stools, encourage p.o. liquids, peri care/skin care

2. Constipation - infrequent passing of stool, resulting in hard, dry stool

a. Nursing care - monitor bowel habits, encourage liquids, roughage in diet, exercise

3. Impaction - stool is retained and becomes harder and drier; more stool packs into the rectum resulting in a mass that cannot be passed

normally; may cause irritation and excess mucus formation which results in diarrhea although impaction remains

a. Nursing care - manual removal of impaction by R.N., prevent from happening again through diet and exercise

VIII. Urinary System

A. Aging process

1. Bladder opening weakens, resulting in incontinence and dribbling.

2. Decrease in bladder muscle tone may also result in urinary retention and infections.

B. Related health problems

1. Retention - inability to empty bladder

   a. Nursing care - monitor frequency and amount of urine voided

2. Incontinence - inability to control release of urine

   a. Nursing care - monitor bladder habits, assist with bladder retraining program, good skin care

3. Kidney infection - caused by microorganism; signs include fever, increased pulse and respiration rate, midback pain, changes in amount and color of urine

4. Bladder infection - caused by microorganism; signs include fever, increased pulse and respirations rate, burning sensation when voiding, frequent voiding, small quantities of urine voided, cloudy urine, bloody urine

   a. Nursing care - encourage proper hygiene. Female, after voiding or stool, wipe front to back

IX. Reproductive System

A. Aging Process

1. Male - enlargement of prostate gland; decreased sperm production

2. Female - menstruation ceases; dryness of vagina

3. Most people continue to need means of sexual expression either by association with another person or by self-stimulation.

B. Related health problems

1. Male (CD-8A)

a. Prostate gland enlargement - occurs in 60-70% of all men over age 50; gland is located at neck of bladder, surrounds urethra, makes opening smaller

(1) Signs: Urinary frequency, nocturia, straining in order to empty bladder, dribbling; complete blockage may require surgery

b. Foreskin cleanliness for uncircumcised

c. Osteoporosis and implications for care.

2. Female

a. Prolapsed uterus - ligaments that support uterus weaken, uterus sags down in vagina

(1) Signs: uterus actually protrudes out of vagina, feeling of fullness in vagina, urinary frequency or infection.

C. Osteoporosis and implications for care

X. Endocrine System

A. Aging process

1. Less hormone production - insulin, thyroxin, pituitary, cortisone, ACTH, estrogen, and testosterone

2. Muscle weakness

B. Related health problems

1. Diabetes

a. Disease in which pancreas does not produce enough insulin

b. Insulin helps control the use of sugar by the body

(1) If sugar is not utilized properly it builds up in the blood.

(2) Excess sugar passes into the urine

(3) Water is needed to dilute this large amount of sugar; therefore, thirst most frequent complaint.

(4) When the body cells are not nourished with sugar, fats are then broken down for energy, acetone is a by-product of this. Acidosis then develops.

c. Signs of hyperglycemia

(1) Frequent urination

(2) Excessive thirst

(3) Weight loss

(4) Headache

(5) Constant hunger

(6) Fatigue

d. Signs may be more severe if untreated.

(1) Flushed face

(2) Heavy breathing

(3) Fruity breath

(4) Stupor

(5) Coma

(6) Death

e. Diabetes can be controlled by diet, exercise, oral medication or insulin.

f. If the client takes insulin, observe for signs of hypoglycemia if he/she takes insulin and does not eat, vomits, or takes too much insulin; these signs may include:

(1) Headache

(2) Dizziness

(3) Hunger

(4) Weakness, shakiness

(5) Sweating

(6) Disorientation

(7) Pallor

(8) Loss of consciousness

e. Nursing care

(1) Good hygiene

(2) Notify nurse of need for nail care.

(3) Protect against injury to legs or feet.

(4) Observe for signs of hypoglycemia or hyperglycemia.

(5) Test urine for sugar and acetone and record.

(6) Make sure client follows prescribed diet.

XI. Skin System (CD-10)

A. Aging process

1. Brittle nails - nails become brittle

2. Sub-cutaneous fat is lost causing a client to feel cold.

3. Hair grays due to loss of pigmentation

4. Bruising under skin due to fragile blood vessels

5. Skin thins, dries, wrinkles and loses elasticity due to decrease in oils and water

6. Brown spots occur especially on areas exposed to sun

B. Related health problems

1. Decubitus ulcer - skin tissue breaks down at certain points on the body

a. Causes - major cause is pressure, irritating substances (wrinkled sheets, foreign objects), poor circulation, wet or moist skin

b. Signs - redness, cyanosis, and discoloration of skin; breaks in skin over bony areas--skin may open as a sore

(1) Nursing care - prevent skin breakdown by a position change every two hours, good perineal and skin care for incontinent client, adequate fluid and diet intake.

C. General nursing care

1. Treat skin gently to avoid tissue damage

2. Wound healing takes longer

3. Apply lotion to bony prominences and itchy skin.

XII. Lymphatic System (CD-11)

A. Aging process

1. Less resistant to disease and infection

2. Wound healing takes longer

B. Related health problems

1. Hodgkins Disease

XIII. Summary and Conclusion

A. Terms and definitions

B. Musculoskeletal system

C. Nervous system

D. Sensory System

E. Cardiovascular system

F. Respiratory system

G. Digestive system

H. Urinary system

I. Reproductive system

J. Endocrine system

K. Skin system

L.. Lymphatic System

The human body is an intriguing structure to study. There has been some new information presented here and it is important for you, the nurse assistant, to be aware of these things as you assist the R.N. in giving excellent nursing care to the clients in your facility or H.H.C.A.

LESSON PLAN: 18

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

INSTRUCTOR NOTE: Classroom discussion items and answers are included to provide the instructor with an optional method of quickly reviewing basic anatomy and physiology.

1. What organs make up the musculoskeletal system: Muscles, bones, and joints
   What are the functions? Movement, protection, support

2. What organs make up the nervous system: Brain, spinal cord, and nerves
   What are the functions? Controls and coordinates the body activities

3. What organs make up the sensory system? Eyes, ears, nose, tongue, and skin

4. What organs make up the cardiovascular system? Heart, blood vessels, and blood
   What are the functions? Carries nutrients and oxygen to cells, and removes wastes (CO2 and dead cells) from cells

5. What structure make up the respiratory system? Nose, mouth, epiglottis, pharynx, larynx, trachea, lungs, bronchi, bronchioles, alveoli
   What are the functions? Provides oxygen to cells, removes wastes in the form of CO2

6. What organs make up the digestive system: Mouth, salivary glands, stomach, small and large intestines, rectum, liver gallbladder, pancreas
   What are the functions? Ingests and prepares food for use by the body and excretes wastes

7. What organs make up the urinary system? Kidneys, ureters, bladder, urethra
   What are the functions? Produces urine, removes waste from blood, and maintains stable balance of water and minerals

8.a What organs make up the male reproductive system? Testes, prostate, penis, urethra, vas deferens

8.b What organs make up the female reproductive system? Ovaries, fallopian tubes, uterus, vagina
What are the functions? Reproduces another being like itself and produces hormones that give each sex distinguishing characteristics

9. What glands make up the endocrine system? Pituitary, thyroid, adrenal, pancreas, gonads (testes and ovaries)
What are the functions? Secretes hormones to regulate body processes of growth and development, and regulates body functions

10. What structures make up the integumentary or skin system? Skins, hair, nails, sweat - and oil-producing glands
What are the functions? Protection, regulates body temperature, excretes wastes

11. What are the organs of the lymph system? Lymph, lymph nodes, tonsils, and spleen
What are the functions? Produces antibodies, manufactures white blood cells, and filters impurities such as dead cells and bacteria

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide into groups of five and discuss observations of the aging process of a family member housed either at home or in a long-term care facility.

LESSON PLAN: 18

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

Match the following terms and health problems to correct definitions by writing the letter in the blank.

_____ 1. Arthritis

_____ 2. Atrophy

_____ 3. Cancer

_____ 4. Cataract

_____ 5. CHF

_____ 6. Constipation

_____ 7. Contracture

_____ 8. CVA

_____ 9. Diabetes

_____ 10. Diarrhea

_____ 11. Emphysema

_____ 12. Expectorate

_____ 13. Fracture

_____ 14. Hypertension

_____ 15. Multiple sclerosis

_____ 16. Organic brain syndrome

_____ 17. Parkinson's

_____ 18. Purulent

_____ 19. Sputum

a. Coughing up matter from the respiratory tract and spitting it out

b. Waste material coughed up from lungs or trachea

c. Decrease in size; waste away

d. When muscle tissue becomes shortened because of spasm or paralysis, either permanently or temporarily

e. Containing pus

f. Inflammation of a joint

g. Growth of abnormal cells into a tumor

h. Serious loss of memory, confusion, poor judgment, impaired ability to care for one's self (because of loss of thinking ability (personality change due to many possible causes some reversible, some not

i. Infrequent passing of stool

j. Disease of brain cells which control movement

k. Heart is unable to pump adequate quantity of blood

l. A broken bond

m. Pancreas does not produce enough insulin

n. Blood vessel in brain either bursts or is blocked

o. Disease which causes degeneration in brain, spinal cord and nerves

p. Lens of eye becomes cloudy

q. High blood pressure

r. Frequent passage of watery stool

s. Elasticity of alveoli in lungs is lost

For each of the following, write "T" if the statement is true, or "F" if it is false.

______20. Swelling, bruising, deformity and loss of movement are signs of a possible fracture.

______21. As a person ages, his/her memory and reflexes usually improve significantly.

______22. CVA means spinal cord injury.

______23. Paralysis on one side of the body and visual problems may be signs of a stroke.

______24. Alzheimer's disease is curable.

______25. As someone ages, there can be a decline in ability to smell and taste.

______26. Blindness may result if glaucoma is untreated.

______27. Arteriosclerosis is hardening and thickening of the arteries.

______28. Narrow arteries causing the BP to rise can lead to a condition known as hypotension.

______29. Hiccoughs could be a sign that the electrical wires are out of place on the pacemaker.

______30. A person with emphysema is often seen pursing his/her lips when exhaling.

______31. Retention is the ability to empty the bladder.

______32. Midback pain bay be a sign of a kidney infection.

______33. Prostate gland enlargement is a common occurrence for men over age 50.

______34. When fats are broken down, acetone is a by-product.

______35. Frequent urination, constant hunger, fatigue, fruity breath are all signs of hyperglycemia.

______36. Hypoglycemia can be the result of taking too much insulin.

______37. Diabetes is a disease that cannot be controlled.

______38. Decubitus ulcers can develop from lying on wrinkled sheets for a long period of time.

______39. The elderly are less resistant to disease and infection because the lymph system does not function as well.

LESSON PLAN: 18

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. f
2. c
3. g
4. p
5. k
6. i
7. d
8. n
9. m
10. r
11. s
12. a
13. l
14. q
15. o
16. h
17. j
18. e
19. b
20. T
21. F
22. F
23. T
24. F
25. T
26. T
27. T
28. F
29. T
30. T
31. F
32. T
33. T
34. T
35. T
36. T
37. F
38. T
39. T

The Aging Process: Nursing Care Points to Remember

I. Musculoskeletal System

1. Observe for signs of injury or disorders such as bruises, redness, swelling, complaints of pain, etc.
2. Use good safety measures: uncluttered halls, doorways, etc. Clean up spills, avoid hazardous conditions.
3. Encourage use of safety devices: handrails, bedrails, call bells, walkers, etc.
4. Provide aids to improve circulation: footrests, comfortable chairs, good positioning and body alignment, change of position, supportive devices.
5. Encourage use of well-fitting supportive shoes.
6. Encourage self-help and exercise within limits of client's capabilities and physician's orders.
7. Use care in handling and assisting; avoid bumping, bruising, or other injuries.
8. Support joints in positioning.
9. Assist with regular ROM and other exercises as ordered.
10. Encourage good nutrition including foods high in protein and calcium. Also encourage good fluid intake.

II. Nervous System

1. Be aware of need for good communication system. Give clear, simple directions. Use aids to communicate, if necessary, such as pictures, word cards, gestures, etc.
2. Use reality orientation.
3. Encourage activity, especially in small groups.
4. Assist with ROM and other exercises--cooperate with PT department.
5. Provide for rehabilitation measures per physician's orders.
6. Provide a safe, secure environment.
7. Offer empathy, reassurance and encouragement.
8. Praise even small successes.
9. Several short periods of activity should be encouraged, instead of one long, overtiring period.

III. Cardiovascular System

1. Observe for signs and symptoms such as edema, shortness of breath, pulse irregularity, cyanosis

2. See that client avoids use of garters, tight fitting clothing, and positions which restrict circulation.
3. Turn and reposition client frequently. Elevate his/her extremities for better circulation.
4. Provide good skin care. Avoid pressure areas when positioning client.
5. Prevent bumps and bruises.
6. See that client uses support hose, if indicated and ordered.
7. Prevent exposure of client to infection.
8. Discourage overeating. Have client avoid salty foods and snacks.
9. Encourage exercise, or give ROM exercises.

IV. Sensory System

1. Provide good light for client.
2. Short periods of "eye work" such as reading, handwork should be encouraged to avoid eye strain.
3. Keep client's glasses clean.
4. Provide uncluttered, safe environment.
5. Check client's ears for wax--keep them clean.
6. DO NOT use sharp objects such as hairpins, Q-tips, etc. to clean ears.
7. Report earwax or other observations to charge nurse.
8. Learn how to operate hearing aids and encourage the client to use one, if needed.
9. Keep the helpless client's nose clean.
10. Provide easy-access container for disposing of soiled tissues.
11. Provide good oral hygiene for all clients, but especially for the helpless. Encourage fluids.
12. Use good feeding techniques and check temperature of food before feeding.

V. Respiratory System

1. Avoid exposing client to colds and other respiratory infections.
2. Use good handwashing procedure.
3. Observe for and report symptoms such as difficult breathing, coughing, rattling lung sounds, etc.
4. Encourage deep breathing when possible. Position to aid breathing - reposition frequently.
5. Avoid overtiring, but encourage exercise.
6. Discourage smoking.
7. Encourage fluids and juices.
8. Avoid sudden temperature changes. Use sweaters, lap blankets, etc. during winter and when air conditioning is in use.

VI. Digestive System

1. Promote good oral hygiene--observe oral cavity and gums, denture fit, etc.
2. Observe for symptoms and complaints such as nausea, pain, distention, "heartburn", loss of appetite, constipation, diarrhea, etc.
3. Use good dietary procedures--encourage a balanced diet and allow plenty of time for client to eat. Encourage self-feeding. Use assistive utensils if needed.
4. Offer and encourage adequate fluids.
5. Encourage good toilet habits. Toilet regularly. Give privacy, insure safety.
6. Encourage exercise and interest in activity.

VII. Urinary System

1. Provide for regular toileting--remind client or take him/her if necessary. Allow for privacy and insure safety.
2. Provide incontinent care and pericare/catheter care.
3. Implement and support bladder training program.
4. Offer encouragement--avoid ridicule of incontinent client. Keep dry--change soiled clothing.
5. Note amount, color, odor and anything unusual about urinary output.
6. Observe for complaints of pain, burning, frequency, etc.
7. Observe male client for inability to void, scrotal swelling, etc.
8. Insure adequate fluid intake, especially water. "Push" fluids if indicated. Record accurate intake and output measurements when ordered.

VIII. Reproductive System

1. Observe for signs of disorders:
   Female - genital swelling, redness, itching, infected glands, vaginal discharge, bleeding and odors
   Male - urinary symptoms, especially inability to void, scrotal swelling
2. Keep genitalia clean, especially uncircumcised male foreskin.

IX. Endocrine System

1. Encourage good nutrition; balanced diet.
2. Work with the diabetic to understand importance of diet, treatment, and exercise.

3. Observe for injury, sores, etc. especially the diabetic.
4. Keep client clean, especially good foot care.
5. Nail trimming of diabetic should be done only by R.N.

X. Integumentary (Skin) System

1. Maintain close observation of skin condition, pressure points, and signs of skin problems.
2. Provide good skin care, keep client dry and clean, use lotion, backrubs with special attention to bony prominences.
3. Avoid pressure areas - turn and position frequently, at least every two hours.
4. Use supportive devices: pillows, "egg carton" or air mattress, sheepskin, heel/elbow pads.
5. Regular bathing with attention to skin folds, perineal area, scalp, feet. Avoid extremes of water temperature. Remove soap by rinsing.
6. Avoid injuries, bumping, bruising, skin tears.
7. Encourage good nutrition - adequate fluid intake.
8. Encourage exercise.
9. Avoid tight clothing such as garters and restraints.

XI. Lymphatic System

1. Avoid injury to client and exposure to colds and other infection.
2. Note healing of sores, injuries.
3. Observe for glandular swelling, especially of neck, underarms, groin.
4. Report complaints of pain.

Developed by Ruth Shultz, R.N. Used with permission.

LESSON PLAN: 19

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

SCOPE OF UNIT:

This unit deals with the individual. As a result of growth and development, significant changes occur during the human life cycle. It is essential that the nurse assistant be aware of the physical changes, mental changes and social changes. We will discuss various health related problems you will encounter daily. This unit also contains information regarding mental confusion which will assist you in understanding how to deal with the confused client.

INFORMATION TOPIC: III-19 OR DEMONSTRATION:

DEATH AND DYING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Identify factors that affect a person's attitude about death.
3. List the five stages of dying.
4. Recognize key points of psychological and spiritual needs of the dying client.
5. Identify specific physical changes associated with the dying process.
6. List four nursing care measures to comfort the dying client.
7. List five signs of death.
8. Identify key points in the care of the body after death.
9. Recognize the nurse assistant's feelings toward death.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #155: "Spiritual Needs of the Patient"
2. Trainex filmstrip #403: "Care of the Patient Who is Dying"
3. Concept Media Filmstrip: "Perspectives on Dying," Program II, "Psychological Reactions of the Dying Person"

LESSON PLAN: 19

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

OUTLINE: (Key Points)

I. Terms and Definitions

  A. Death - permanent stoppage of all vital functions of the body

  B. Postmortem - after death

  C. Rigor mortis - temporary rigidity of muscles of the body occurring after death.

II. Factors Affecting Attitudes About Death

  A. Personal experience

  B. Culture

  C. Religion

  D. Age

III. Five Stages of Dying (as identified by Elisabeth Kubler-Ross) (Can be applied to any loss)

  A. Denial

    1. Individual refuses to believe he/she is dying. The person thinks, "No, not me."

    2. The NA needs to be available to the client; allow him/her to deny impending death. Just listen.

  B. Anger CD1

    1. Individual is envious and resentful of those who have life and health; it is directed at those around him/her; the person thinks, "Why me?"

    2. The NA must accept the anger if it is in an acceptable form. Realize it is not directed at you.

C. Bargaining

1. Individual tries to gain more time; usually done with God; the person thinks, "Yes, me, but . . ." looks for new "cures." Tries anything to get well.

2. The NA should understand the client is trying to buy more time; he/she is beginning to accept the reality of his/her fate.

D. Depression

1. Individual is very sad and mourns over things he/she will never do; the person thinks, "Yes, me."

2. The NA should not try to cheer up the client. Realize that the client is mourning. N.A. should listen or be nearby to make occasional contact.

E. Acceptance

1. Individual experiences peace and calm; is ready to accept death. Reaching this stage of acceptance does not mean that the time of death is near. Many elderly clients have reached this point. Resignation - not a true acceptance; giving up.

2. The NA should assure the client that he/she will be given the best nursing care possible.

F. It is desirable for dying clients to progress through the five stages; the client may never get beyond a certain stage or he/she may move back and forth between stages. Some clients remain in one stage until death. He/she may never reach acceptance.

G. The client's family may also experience the same stages of mourning that the client is going through.

1. They too are trying to prepare for the impending death.

2. The support to be offered by the NA is very much like that for the client.

3. Being available to just listen is most important.

IV. Psychological and Spiritual Needs CD-1; CD-3

A. The NA needs to use two important aspects of communication when dealing with the dying clients.

    1. Listening - the client is the one who needs to talk; may be encouraged to discuss his/her feelings, concerns and worries by the presence of one who will listen

    2. Touch - conveys caring and concern to the client when words cannot; reaffirms the client's humanness; mere presence at bedside is important.

  B. The NA must respect the client's spiritual needs.

    1. Assist in obtaining spiritual guidance for the client who may wish to see a priest, rabbi, or minister or other spiritual advisors.

    2. Provide privacy during spiritual moments and show courtesy when clergy visits.

    3. Assistance in obtaining spiritual support may be needed by the family at the immediate time of death.

V. Physical Needs

  A. The process of dying may involve a few minutes/hours or it may take days or weeks. There is a general slowing down of body functions and changes in the level of consciousness.

  B. Specific changes

    1. Vision becomes blurred and gradually fails; increased amounts of secretions accumulate in the corners of the eyes.

    2. Speech becomes more difficult.

    3. Hearing is one of the last senses and functions to be lost.

    4. Mucus may accumulate in the mouth as the client is unable to swallow.

    5. Urinary and stool incontinence may develop or urinary retention and constipation.

  C. Nursing care measures to comfort the dying client

    1. Room should be well-lighted, but bright lights and glare should be avoided.

    2. Give good eye care.

3. Even though it may be difficult for the client to speak, you should still talk to him/her; ask questions so he/she can answer with a simple yes or no.

4. Speak in a normal voice--do not whisper; keep in mind that the client may still be able to hear. Do not say things that you would not want to client to hear. Offer reassurance and give explanations.

5. Oral hygiene is very important.

6. Give good peri care; keep client clean and dry.

7. Good skin care and frequent position changes; good body alignment and supportive devices will help client feel more comfortable.

8. Report to charge nurse if client appears to be in pain or complains of pain.

VI. Signs of Death

A. Eyes have a glossy appearance, stare into space.

B. Movement, muscle tone and sensation are lost.

C. Peristalsis slows down, noted by abdominal distention, incontinence, impaction, nausea and vomiting.

D. Circulation fails and body temperature rises. Client feels cool, appears pale, and perspires heavily. Arms and legs become cyanotic/mottled.

E. Pulse is fast, weak and irregular; BP begins to fall.

F. Respirations fail - become very slow; Cheyne-Stokes; or rapid and shallow

G. Mucus collects in the client's throat causing a sound called the "death rattle."

H. Level of consciousness varies--from drowsy, stupor (may still be aroused), to coma (loss of consciousness). Some people do not lose consciousness until the moment of death.

I. The client is pronounced dead when there is absence of a pulse, respirations and blood pressure. The pupils are fixed and dilated.

VII. Care of the Body After Death (CD-2)

A. Use the facility's procedure.

B. Proper care is needed after death to maintain good appearance of the body and prevent damage to the skin.

C. Treat the body with respect.

D. Rigor mortis is the stiffness or rigidity of skeletal muscles that occurs after death; it will occur within two to four hours after death.

E. Close the eyes, using eye lashes, remove equipment, bathe soiled parts, replace soiled dressings, and put dentures in a labeled container.

F. Valuables and personal possessions should be gathered for the family.

G. Cover the body to the shoulders with a sheet if the family is to view the body.

H. Provide privacy for family when they visit.

VIII. The Nurse Assistant's Feelings Toward Death (CD-2)

A. Learn to express feelings to someone (friends, family, co-worker)

B. Realize you are a person with emotions and feelings--it is okay to feel sad when someone you care about dies.

C. No one has the answer to how to deal with death--it is an experience of which we are unsure of the outcome.

IX. Summary and Conclusion

A. Terms and definitions

B. Factors affecting attitudes about death

C. Five stages of dying

D. Psychological and spiritual needs

E. Physical needs

F. Signs of death

G. Care of the body after death

H. The NA's feelings toward death

You have learned about the stages people go through when faced with a loss--a life, loved ones, a body part, even a pet. You must not forget that a dying person needs to be kept clean and comfortable and have company until the end of life. It is important that you discuss your feelings about death with a friend or your supervisor.

LESSON PLAN: 19

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

CLASSROOM DISCUSSION:

1. What can a CNA do to help ease the emotional pain for the client and/or family?
2. How do you feel about performing physical care for a post-mortem client?
3. If a member of your family was dying, how would you expect them to be treated?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Have students write down their feelings about death by answering these questions:

1. If you only had one more day to live, how would you spend it?
2. Where would you rather die, in a hospital, nursing home or at home?
3. How does the age of a person affect your feelings about death?
    a. Have students write a "Letter to Death". Share with class only if desired.

LESSON PLAN: 19

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

EVALUATION ITEMS:

1. Define the following terms.

   a. Death

   b. Postmortem

   c. Rigor mortis

2. Factors that affect a person's attitude about death are: (Circle the letter of the correct answer.)

   a. Culture
   b. Age
   c. Religion
   d. All of the above

3. List the five stages of dying as identified by Kubler-Ross.

   a.

   b.

   c.

   d.

   e.

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 4. Listening and touch are two important aspects of communication when dealing with the dying client.

______ 5. The NA should provide privacy during spiritual moments and show courtesy when clergy visits.

______ 6. Vision usually improves during the dying process.

______ 7. Hearing is one of the first senses to be lost.

______ 8. Urinary and stool incontinence may develop during the dying process.

9. List four nursing care measures to comfort the dying client.

a.

b.

c.

d.

10. List five signs of death.

a.

b.

c.

d.

e.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______11. Rigor mortis will not occur until 12 hours after death.

_______12. Treat the body with respect when caring for it after death.

_______13. The body should be bathed and soiled dressings changed after death.

_______14. It is not appropriate for the NA to show any emotion after a client dies since this will upset co-workers and other clients.

_______15. It is important for the NA to be able to express his/her feelings toward death to someone close to him/her.

LESSON PLAN: 19

COURSE TITLE: NURSE ASSISTANT

UNIT III : THE CLIENT

ANSWERS TO EVALUATION ITEMS:

1. a. Death - permanent stoppage of all vital functions of the body
   b. Postmortem - after death
   c. Rigor mortis - temporary rigidity of the muscles of the body occurring after death

2. d
3. a. Denial
   b. Anger
   c. Bargaining
   d. Depression
   e. Acceptance
4. T
5. T
6. F
7. F
8. T
9. The student may list any four of the following:

   a. Room should be well lighted, but bright lights and glare should be avoided.

   b. Give good eye care.

   c. Even though it may be difficult for the client to speak you should still talk to him/her; ask questions so he/she can answer with a simple yes or no.

   d. Speak in a normal voice--do not whisper; keep in mind that the client may still be able to hear. Do not say things that you would not want the client to hear. Offer reassurance and give explanations.

   e. Oral hygiene is very important.

   f. Give good peri care; keep client clean and dry.

   g. Good skin care and frequent position changes; good body alignment and supportive devices will help client feel more comfortable.

   h. Report to charge nurse if client appears to be in pain or complains of pain.

10. The student may list any five of the following:

    a. Eyes have a glossy appearance, stare into space.

    b. Movement, muscle tone and sensation are lost.

    c. Peristalsis slows down, noted by abdominal distention, incontinence, impaction, nausea and vomiting.

    d. Circulation fails and body temperature rises. Client feels cool, appears pale, and perspires heavily. Arms and legs become cyanotic/mottled.

    e. Pulse is fast, weak and irregular; BP begins to fall.

    f. Respirations fail - become very slow; Cheyne-Stokes; or rapid and shallow.

    g. Mucus collects in the client's throat causing a sound called the "death rattle."

    h. Level of consciousness varies--from drowsy, stupor (may still be aroused), to coma (loss of consciousness). Some people do not lose consciousness until the moment of death.

    i. The client is pronounced dead when there is absence of a pulse, respirations and blood pressure. The pupils are fixed and dilated.

11. F
12. T
13. T
14. F
15. T

LESSON PLAN: 20

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: IV-20 OR DEMONSTRATION:

SAFETY MEASURES FOR THE CLIENT AND THE ENVIRONMENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify which clients require specific safety measures.
2. Identify nursing care measures in client safety.
3. List two reasons for applying safety devices.
4. Identify and describe at least four safety devices.
5. Demonstrate or describe the use of each safety device.
6. Identify how often a restrained client shall be checked and how often restraints are released.
7. Identify measures to provide a safe LTC environment.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Safety Devices
    - a. Bed with side rails
    - b. Safety vest or jacket
    - c. Posey/safety belt
    - d. Wrist/ankle restraints
    - e. Mitten
2. HO 2: Hydraulic lift and Transfer belt

TEACHER RESOURCES:

INTRODUCTION:

Safety is a basic need of every human. The LTC client is frequently dependent upon the caregiver to provide safety for him or her. It is a responsibility of the NA to monitor for and report anything that may lead to an accident or injury of a client, visitor, or staff member.

There may be instances in caring for the client in the long term care facility when equipment must be used to help keep the clients safe. Restraints should be used only when all other measures to keep the client safe have failed. Even when the client may be confused, an explanation should be given of why the restraints are being applied. The decision to restrain a client should be made after careful assessment by the nurse and an order from the doctor is obtained. Never show an attitude of punishment with regard to restraints and make sure the skin is well padded and protected to prevent burns under the restrained area.

J. Allow smoking only under supervision and in approved areas. Supervise clients when they smoke, particularly if weak, unsteady, or confused.

K. Allow client to adjust to changes in position before asking them to move.

L. Lock brakes on wheelchair, shower chair, or geri-chair when not being moved.

M. When bathing client, take precautions to avoid burning with hot water.

   1. Use a bath thermometer, if available.

   2. Check water temperature with inner forearm if thermometer not available.

N. Correctly apply all safety devices.

O. Assess client's ability to ambulate; check for:

   1. Unsteady gait

   2. Unbalanced - holds on to objects

   3. Posture

   4. Complaints of dizziness

III. Reasons for Using Safety Devises (CD-3)

A. To help a client maintain proper body position and balance

B. To ensure a client's safety

C. To keep a confused client from disrupting a treatment procedure, such as an IV, naso-gastric tube, dressing

D. To prevent a severely emotionally disturbed client from injuring himself/herself or others

IV. Types of Safety Devices

A. Bed side rails (CD-4)

   1. Metal frames placed on sides on bed

   2. Prevent client from falling out

   3. Do not prevent client from climbing out

   4. Must be securely attached

5. Should be used for clients who are blind, confused, unconscious, sedated, have muscular disabilities and seizures.

6. Rails may be lowered while working at bedside.

7. Remember to raise before leaving client; be sure both sides are up.

8. Always explain the purpose.

9. Make sure call light is within reach

B. Safety jacket or vest

1. Canvas or mesh vest with tails that are crossed behind the client, then tied behind the client's chair or tied to the bed frame; should never be attached to bed side rails

2. Used for the more confused client who may climb over bed side rails; or for postural support while in a chair

3 Never use while client is on a bedside commode or toilet.

4. Avoid wrinkles or knots that may exert pressure on the client's skin.

5. Check every 30 minutes and remove and exercise every two hours.

C. Safety or posey belt

1. Canvas or cloth strap large enough to be placed around the client's waist and tied to bed frame on both sides

2. Serves the same function as safety vest; used for same reasons

3. Check skin for any signs of pressure: discoloration of skin, indentations, redness.

4. Check every 30 minutes, and remove and exercise every two hours.

D. Wrist or ankle restraints

1. A soft type cloth such as linen or muslin that is used to form a strap that slips on the wrist or ankle and tied to the bed frame--padding should be on the limb before applying to prevent skin irritation.

2. Used only as necessary to prevent a client from disrupting a procedure; may also be used for severely agitated client to prevent self-injury or injury to others.

3. Thorough explanation to be given before applying

4. Apply in such a manner that the client will not tighten it if he/she pulls on it.

5. Restraints should be loosened or removed one at time and limbs exercised, at least every two hours.

6. Check circulation for impairment due to applying restraints too tight or if limb is restrained in an abnormal position.

7. Signs of impaired circulation

    a. Blueness

    b. Pallor

    c. Skin is cool or cold to touch

    d. Client complains of tingling sensation

8. Restore circulation if any of the above signs are noted by loosening restraint, exercising and massaging limb.

E. Mittens

1. A devise made of soft material that completely covers the hand; prevents grasping but does not restrict movement

2. Used for confused client who may disrupt a procedure (IV)

3. Check circulation as stated for wrist restraints.

4. Remove every two hours and exercise hand.

F. Transfer belt

1. Canvas belt with an adjustable buckle used when transferring or ambulating clients

2. Placed around the client's waist; the nurse assistant grasps the belt to provide support to the client

G. Hydraulic lift

1. A hydraulic lift with a one-piece canvas sling for transferring the extremely heavy or handicapped client
2. Use discretion and common sense in determining if a severely spastic or handicapped client can be lifted with the lift.

V. Additional Points in Applying Restraints (CD-5,6,7,8)

A. A geriatric chair (geri-chair) is a rolling chair with a high back that has a removable tray in the front; used for postural support; check placement of tray--should not be pushed too tightly against the client waist or breasts.

B. There must be a physician's order before applying restraints (except in an emergency situation).

C. Always explain what you will be doing and why.

D. Clients requiring restraints shall be checked every 30 minutes and released and exercised every two hours and given the opportunity to use toilet facilities. Offer fluids to drink; change the client's position.

E. Put padding on any skin area that may be irritated by application of safety device.

F. Use a minimum of restraint to effectively protect the client.

G. Give the client the most movement possible, but still insure safety; secure ties where the client cannot reach them and undo them.

H. Keep scissors handy in case of an emergency in which you need to cut a safety device so the client can be moved quickly.

I. Be sure call light is within reach.

J. Inform family of the purpose of restraint.

K. Ask client and family to notify nurse if restraint is causing discomfort.

L. Provide pillow props (positioning of soft props) as needed to assure good body alignment.

VI. Safety Measures for the Environment (CD-9)

A. Clean up untidy conditions in the client's room.

B. Keep all walkways free of hazards, such as shoes, chair, bedcranks, etc.

C. Wipe up anything that spills on the floor immediately. Post a "Wet Floor" sign while it is drying.

D. Encourage use of handrails and grab bars in the shower, bathroom and hallways.

E. Examine wheelchair, shower chairs, geri-chairs, walkers or any other equipment for broken parts; if any are found, report to charge nurse.

F. Never handle electrical equipment with wet hands or near water.

G. Do not use extension cords except as a temporary measure and then for only one appliance and not more than six feet in length.

H. Inspect cord and plugs for fraying or defects before plugging in; never place cords over client, place under bed.

I. Report any equipment that causes electrical shock when handled.

J. Post emergency phone numbers near each telephone.

K. Leave articles such as water glasses, wipes, and signal devices within reach of resident.

L. Provide adequate lighting.

M. Remove scatter rugs or tack the rugs down.

N. Keep all poisonous substances in high places.

O. Doors to stairways should be closed and locked when dealing with a child or confused adult.

TEACHER RESOURCES:

INTRODUCTION:

Caring for a dying client can be one of the greatest challenges of a health care worker. Even though we are well aware that all life must end in death, we tend to avoid thinking about this until we are actually faced with the situation. Today's life span has been increased with the coming of improved health care and medications, however, death is still the last learning experience. It is very important that you, as a nurse assistant, form your own feelings about death so you can comfort and assist the dying client and his/her family.

This lesson will assist you in that by identifying the stages that a client and/or the family faced with a terminal illness may go through. We will also discuss the psychological, spiritual and physical needs of the dying client and how to determine when a client is near death.

LESSON PLAN: 20

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

OUTLINE: (Key Points)

I. Client Conditions that Require Specific Safety Measures (CD-1)

   A. Confused - due to medication, poor nutritional status, emotional disturbance, disease of brain, or disease of cardiovascular system

   B. Elderly

      1. Aging process - there is a decrease in the senses (taste, touch, smell, hearing, and vision); client is less aware of danger warning signals

      2. Decreased reaction time to danger

   C. Client sedated with drugs

   D. Unconscious client

II. Safety Measures for All Clients (CD-2)

   A. Check eyeglasses for cleanliness; make sure client wears them.

   B. Check hearing aid to make sure it is functioning properly; make sure client wears it.

   C. Handle mechanical aids with care; can be expensive to replace if damaged.

   D. Place signal cord within reach of client at all times; client may injure self trying to get light.

   E. Check bed brakes; should be in lock position unless moving the bed.

   F. Side rails should be up when indicated, check with charge nurse.

   G. Keep bed in low position to decrease danger of falls.

   H. When feeding clients, take precautions to avoid burns from hot food.

   I. Give instructions clearly to prepare client for an activity.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Personal Needs
2. Trainex filmstrip #457: "Change and Loss: The Challenges of Aging"
3. Projector (F.S.)
4. Film - "Mrs. Reynolds Needs a Nurse"
   Dept. of Public Health, State of Connecticut
5. 16 mm. projector

VII. Summary and Conclusion

A. Client conditions that require specific safety measures

B. Safety measures for all clients

C. Reasons for using safety devices

D. Types of safety devices

E. Additional points in applying restraints

F. Safety measures for the environment

As a nurse assistant you have the responsibility of providing safety for your clients. Keep these factors in mind every minute while at work. It is extremely important because so many of your clients are dependent upon you to meet this basic human need.

LESSON PLAN: 20

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. What type of clients may require more frequent observances of safety factors?
2. When taking care of clients what are some safety measures to keep in mind?
3. What are some reasons for applying a restraint?
4. What types of safety devices have you used on clients?
5. What is necessary before applying a restraint?
6. How often are restraints removed?
7. What precautions should be taken when using restraints on a client whose skin is very fragile?
8. What signs would you look for that would tell you the restraint is on too tight?
9. When you think of the LTC environment, what other safety measures should be considered?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students restrained during class with various restraints.
2. Have students locate brakes on beds, w/c, geri-chair and shower chairs and apply brake and release.
3. Demonstrate application of each type of restraint.
4. Have students practice applying restraints on each other.
5. Discuss students' feelings about being restrained.

LESSON PLAN: 20

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS:

1. List two client conditions that may require specific safety measures.

a.

b.

2. List four safety devices.

a.

b.

c.

d.

3. List two reasons for applying restraints.

a.

b.

4. How often do you check a restrained client?

5. How often do you release the restraint and exercise the client?

6. Which of the following is not a sign of impaired circulation? (Circle the letter of the correct answer.)

   a. Blueness
   b. Skin is warm to touch
   c. Pallor
   d. Client complains of tingling sensation

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 7. Keeping the bed in the low position will decrease the danger of falls.

______ 8. Eyeglasses have nothing to do with safety for the client.

_______ 9. Bed brakes should be unlocked at all times.

_______ 10. Allow the client to adjust from a lying down (supine) to sitting up position before transferring to a chair.

_______ 11. The only reason to apply a safety device is to ensure a client's safety.

_______ 12. It is not appropriate to lower a side rail while you are working at that side of the bed.

_______ 13. A physician's order is needed to apply restraints unless it is an emergency situation.

_______ 14. The more restraints the nursing assistant can use on a client, the better protected they will be.

_______ 15. No explanation should be given to clients when applying restraints because this makes them harder to control.

_______ 16. Clients should be allowed as much movement as possible but kept within limits of safety.

_______ 17. Extra padding should be used if the client's skin is very thin.

LESSON PLAN: 20

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:
   a. Confused
   b. Elderly
   c. Client sedated with drugs
   d. Unconscious

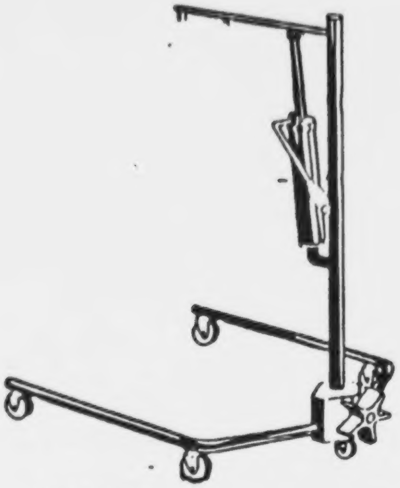
2. The student may list any four of the following:
   a. Bed side rails
   b. Safety jacket or vest
   c. Safety or posey belt
   d. Wrist or ankle restraints
   e. Mittens
   f. Transfer belt
   g. Hydraulic lift

3. The student may list any two of the following:
   a. To help a client maintain proper body position and balance
   b. To ensure a client's safety
   c. To keep a confused client from disrupting a treatment procedure, such as an IV, naso-gastric tube, dressing
   d. To prevent a severely emotionally disturbed client from injuring himself/herself or others

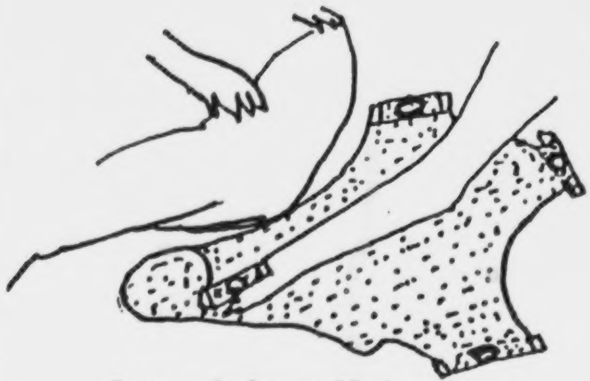
4. Every 30 minutes
5. Every two hours
6. b
7. T
8. F
9. F
10. T
11. F
12. F
13. T
14. F
15. F
16. T
17. T

HYDRAULIC LIFT/TRANSFER BELT

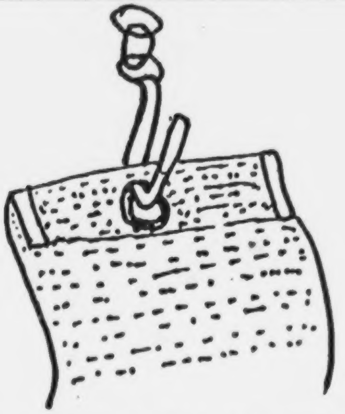
HO 2



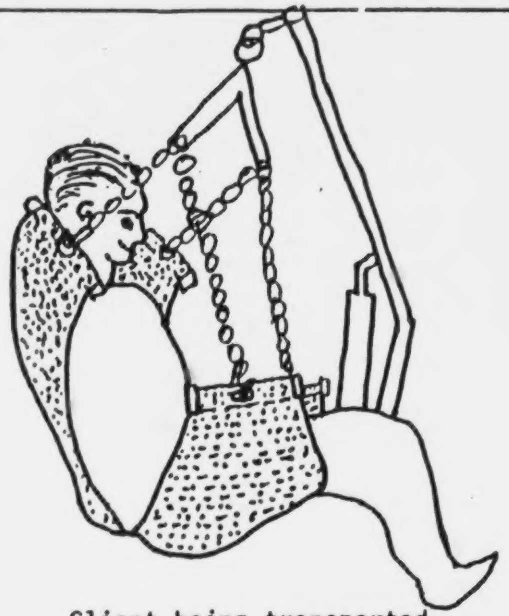
Hydraulic lift



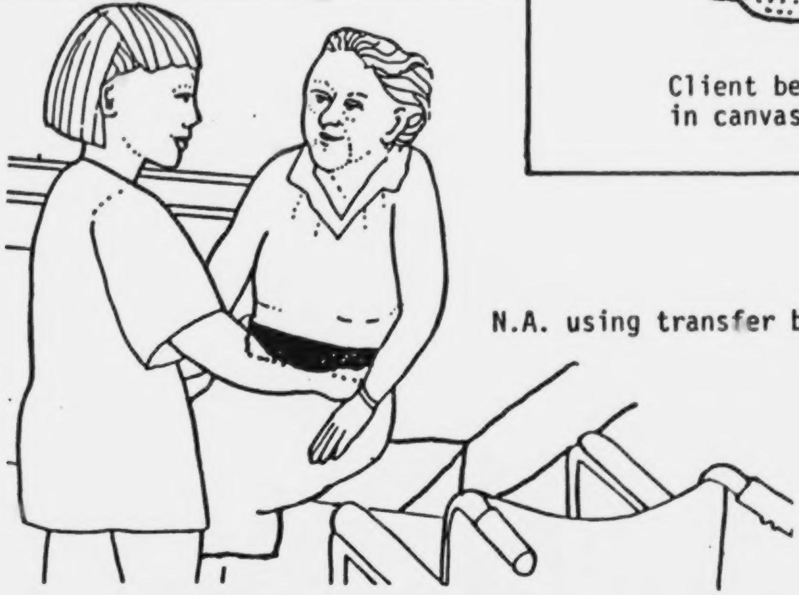
Canvas being rolled under side-lying client



Hook through metal bar and canvas MUST be AWAY from client's body



Client being transported in canvas by mechanical lift



N.A. using transfer belt

LESSON PLAN: 21

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: IV-21 OR DEMONSTRATION:

FIRE, NATURAL DISASTERS, AND OTHER EMERGENCIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2 Identify methods of fire prevention.
3. Describe what to do in case of fire.
4. Identify the difference between tornado watch and tornado warning.
5. Discuss what actions should be taken should an earthquake occur.
6. Identify steps to control hemorrhage from a cut.
7. Demonstrate the proper steps to follow should a client fall while attended.
8. Demonstrate the proper steps to follow should a client fall while unattended.
9. List observations that should be made during a seizure.
10. Identify precautions to avoid choking.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Moving Client to Safety
2. HO 2: Safely Handling a Falling Client
3. HO 3: Sign of Choking
4. Fire extinguishers
5. Facility Floor Plan
6. Film: "Drop, Drag, and Carry" from Fire Prevention through Films, Inc.
7. Projector

TEACHER RESOURCES:

INTRODUCTION:

The nurse assistant must be aware of what to do if faced with a disaster or emergency. Many times we do not think about these things beforehand. It is necessary for you to concentrate on this information since these are not everyday occurrences. An emergency requires quick action, and your client will be depending upon you once again for assistance and reassurance.

LESSON PLAN: 21

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Extremities - the arms, legs, hands, and feet

   B. Hemorrhage - excessive, uncontrolled bleeding

   C. Obese - extremely fat

   D. Obstruction - a blockage

   E. Seizure - sudden, violent involuntary contraction of a group of muscles

   F. Supine - lying on one's back

   G. Unconscious - lacking in awareness of the individual

   H. Ventilate - give air to

II. Fire Safety

   A. Fire Prevention

      1. Smoking is the number one cause of fires in health care institutions.

      2. Never empty ashtrays into any container that may contain flammable materials. MOISTEN ASHTRAY CONTENTS BEFORE DISCARDING

      3. Allow smoking only under supervision and in approved areas.

      4. Study and understand the fire evacuation plan.

      5. Know the facility/home's floor plan and location of all fire alarms.

      6. Know locations of fire extinguishers and how to use each type. Fire extinguisher should be in kitchen.

      7. Remove all grease from stove.

      8. If there is a grease fire, cover it, pour salt or baking soda into it or use chemical fire extinguisher. NEVER PUT WATER ON A GREASE FIRE.

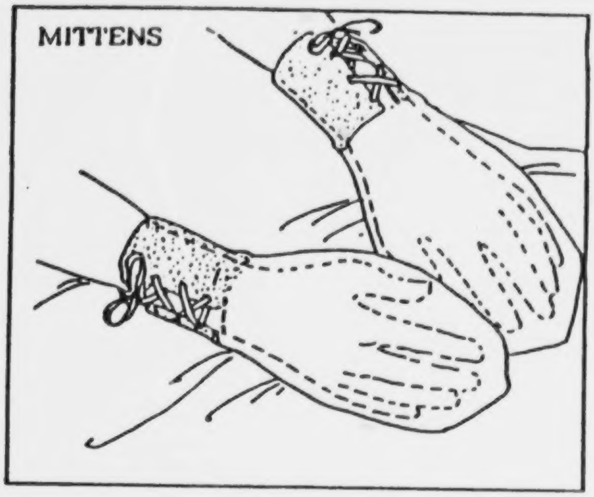
9. Never prop open a fire door.
10. Participate in fire drills.
11. Check for smoke alarms.
12. Exits should be clearly designated and not obstructed.
13. Report any fire hazards you find to charge personnel immediately.
14. Do not use extension cords except as a temporary measure and then for only one appliance and not more than six feet in length.
15. Have scissors within easy reach to remove restraints in case of an emergency.
16. Know precautions needed for storage and use of oxygen.
17. Use proper precautions with combustible cleaning compounds.
18. Follow facility policies regarding lights, Christmas trees, appliances, etc.

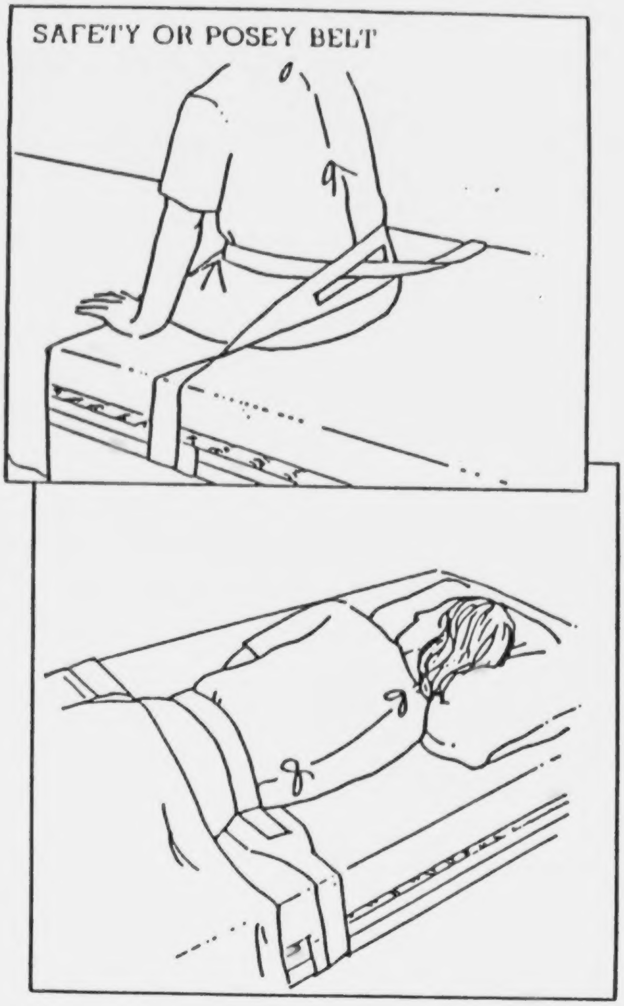
B. In case of fire (CD-2,3)

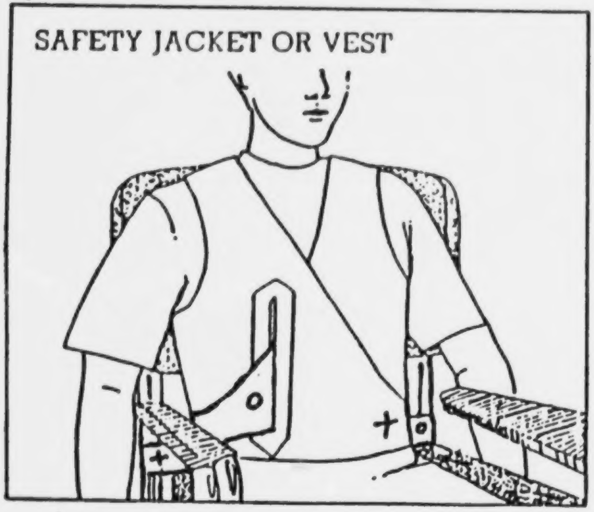
1. Remove client(s) from the area of immediate danger to the nearest safe area.
2. Close the door of that room as you leave. This is an absolute must if the fire is in that room.
3. Notify the fire department immediately.
4. Calmly notify another employee in the home of the fire--preferably the charge nurse.
5. All employees proceed to their assigned fire stations and begin preassigned duties, such as closing fire and smoke doors, windows, removing additional clients adjacent to danger area, shutting off mechanical equipment.
6. Attempt to extinguish the fire with the proper fire extinguisher; remember to always feel door before entering; if warm to touch, wait and let fire department handle it.

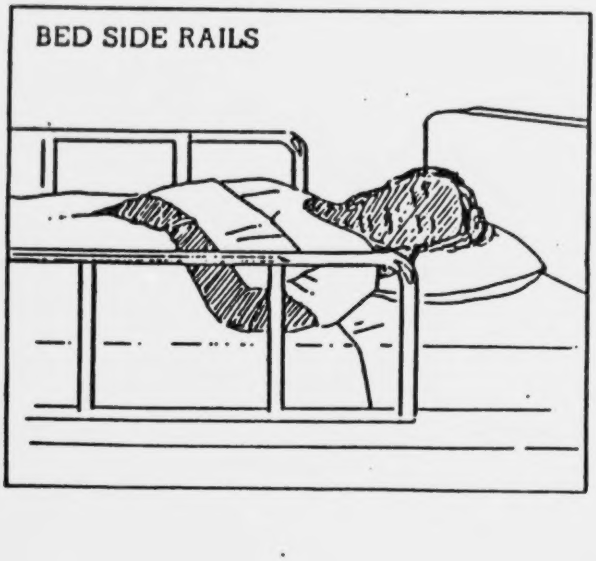
SAFETY DEVICES

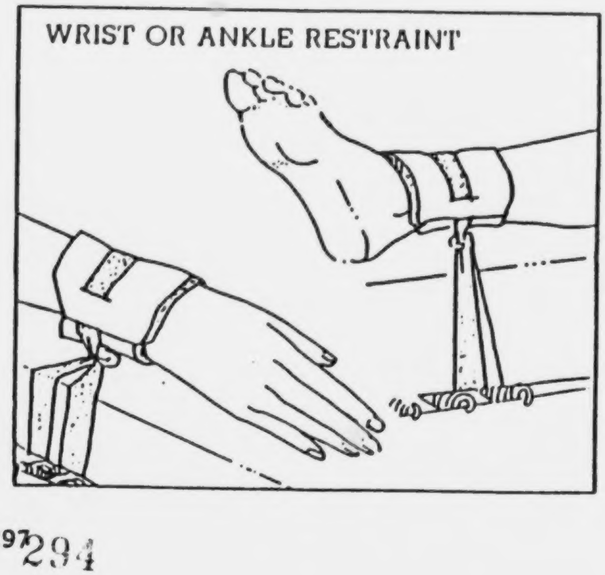
HO 1


MITTENS


SAFETY OR POSEY BELT


SAFETY JACKET OR VEST


BED SIDE RAILS


WRIST OR ANKLE RESTRAINT

(3) Gently lower yourself to the floor, keeping your back straight.

(4) Call for help immediately.

(5) Do not move the client until examined by charge nurse.

C. Seizures

1. A seizure is a convulsion - sudden, periodic attacks of muscles contracting and relaxing.

2. Follow these steps if you think a client is having a seizure.

   a. Clear the area around the client of anything hard or sharp.

   b. Loosen anything around his/her neck that may make breathing difficult.

   c. Put something flat and soft under her/his head.

   d. Turn the client gently on his/her side-- helps keep airway clear. Do not try to force her/his mouth open with any hard object or with your fingers. A person having a seizure cannot swallow his/her tongue and efforts to hold her/his tongue down can injure the teeth or jaw.

   e. Do not hold the client down or try to stop his/her movements.

   f. Stay with the client until the seizure has ended.

   g. Observe and note the following:

      1. Time seizure started and how long it lasted

      2. If the seizure started at a certain area of the body or was generalized from the start

      3. If the client was incontinent

D. Choking

1. Elderly clients may be more prone to choking due to weakened muscles of mouth and throat (CD-8)

2. Take the following precautions to avoid choking when feeding a client:

   a. Cut food into small pieces.

b. Do not rush client--allow him/her time to chew the food thoroughly and swallow it before giving more.

c. Make sure dentures are in place and fit properly.

3. To determine if a client is actually choking, observe for the sign of choking. (HO-3)

4. If the client is able to cough, speak, or breathe, leave him/her alone. Starting the procedure at this point may cause him/her to breathe in harder and force the object further down in the respiratory tract.

5. If at any point the client develops difficulty breathing or is unable to cough or speak, start the procedure for airway obstruction (lesson plan 22).

6. The Heimlich maneuver is usually sufficient to "pop" the obstructing object out of the client's airway--the maneuver forces air out of the lungs pushing the object out with it.

VI. Summary and Conclusion

A. Terms and definitions

B. Fire safety

C. Tornado safety

D. Earthquake safety

E. Emergency situations

This information is fresh in your mind, and you would probably be able to respond appropriately and quickly if faced with any of the situations mentioned. It is important, though, for you to review this lesson plan periodically because in six months to a year from now it will not be as fresh in your mind. To perform in a safe manner you must be acquainted with the proper way of handling all of these situations.

LESSON PLAN: 21

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. What are some things that may cause a fire in the facility?
2. What is the first thing you do when you find a fire?
3. Who do you evacuate first?
4. What is the difference between tornado watch and warning?
5. Have any of you ever been in a tornado? What was is like?
6. If you are in the facility during an earthquake, where would be a good place to take cover?
7. Why don't you apply a tourniquet?
8. What are some things you do help prevent choking?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Have students demonstrate how to remove a bedridden client during a fire.
2. Have students locate fire alarms, extinguishers, and exits in the facility.
3. Demonstrate proper use of fire extinguishers.
4. Show film.
5. Have students practice falling with another student (one as the NA and the other as the client.
6. Demonstrate proper way to smother a grease fire.

LESSON PLAN: 21

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

______ 1. Extremities

______ 2. Hemorrhage

______ 3. Obese

______ 4. Obstruction

______ 5. Seizure

______ 6. Supine

______ 7. Unconscious

______ 8. Ventilate

a. The arm, legs, hands, and feet

b. Give air to

c. Excessive uncontrolled bleeding

d. Lying on one's back

e. Sudden, periodic attacks of muscles contracting and relaxing

f. Extremely fat

g. Lacking in awareness of the individual

h. A blockage

9. The number one cause of fires in health care institutions and homes is from: (Circle the letter of the correct answer.)

   a. Faulty wiring
   b. Smoking
   c. Too many things plugged into one outlet
   d. Using flammable liquids around gas (from dryers, hot water heaters)

For each of the following, write "T" if the statement if true, or "F" if it is false.

______10. If a fire occurs in a client's room, immediately leave to get a fire extinguisher.

______11. The client in a w/c must be evacuated first

______12. Cover your mouth and nose with a wet washcloth during a fire to reduce smoke intake.

______14. All windows should be closed when preparing for a tornado.

______15. A tornado watch means conditions are such that a tornado may develop.

______16. If a client appears seriously injured after an earthquake, do not attempt to move him unless there is immediate danger of further danger.

______17. One of the first steps to take if someone is bleeding is to apply a tourniquet.

______18. Protecting the client from further injury during a seizure is very important.

______19. It is important to note at what time the seizure started and how long it lasted.

Answer the following:

20. You enter Mrs. Taft's room. There are some flames shooting up from a wastebasket, they are igniting the bedspread. Mrs. Taft is in the bathroom. What steps will you take?

21. List four emergency situations you may be faced with at some point when taking care of clients.

a.

b.

c.

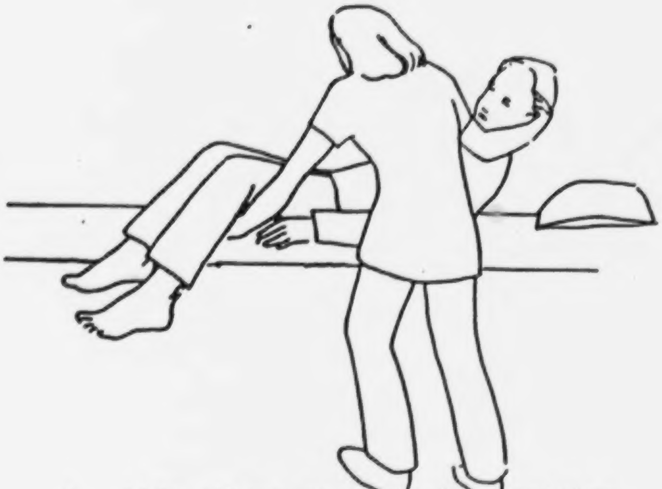
d.

22. You enter the room of Mrs. Harris, you find her lying on the floor beside her bed. She is crying, What will you do.

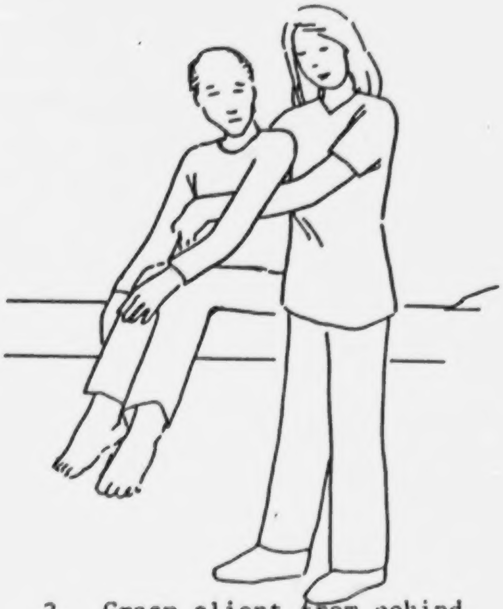
23. To avoid choking when feeding a client do all of the following except: (Circle the letter of the correct answer.)

a. Cut food in small pieces.
b. Give manageable amounts of food at a time.
c. Don't bother putting dentures in.
d. Allow the client to chew and wall the food.

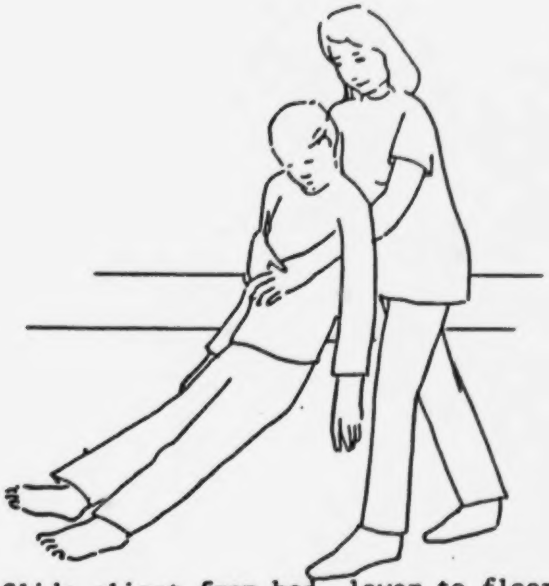
MOVING CLIENT TO SAFETY



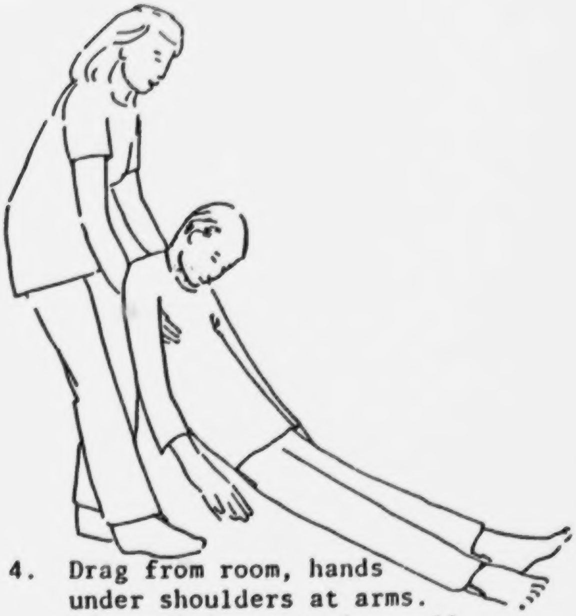
1. Lift client to a sitting position, legs over side of bed.



2. Grasp client from behind, under arms.

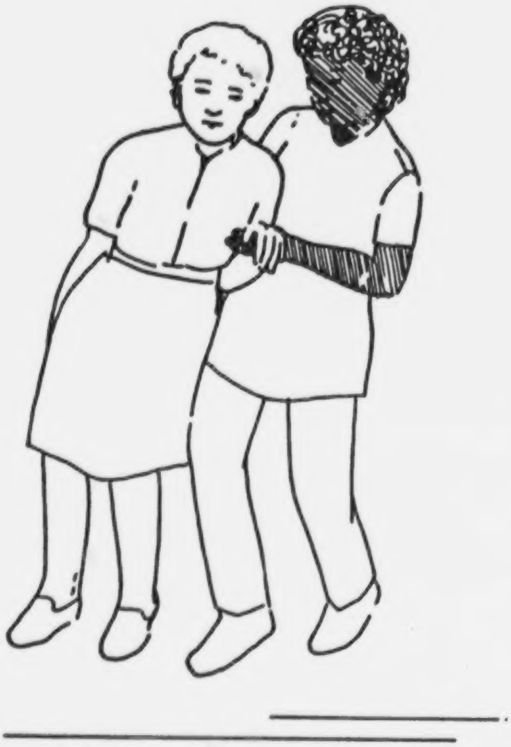


3. Slide client from bed, lower to floor.

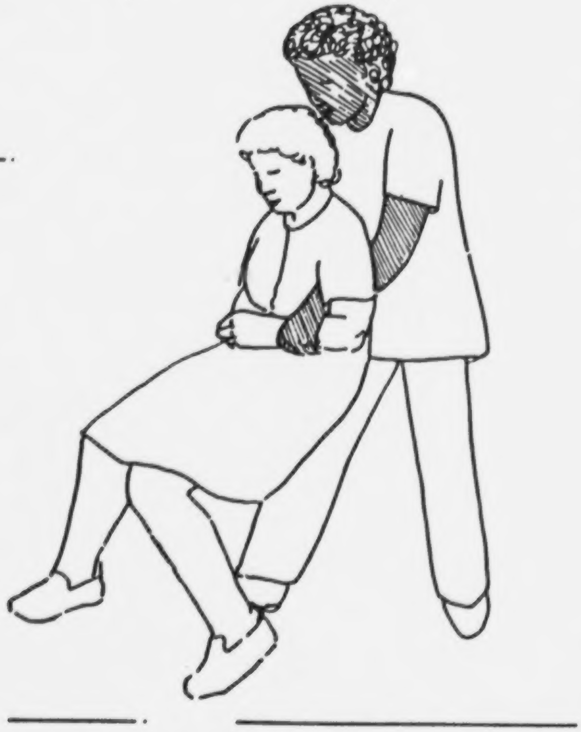


4. Drag from room, hands under shoulders at arms. If conditions permit, roll client onto blanket, then drag from room.

SAFELY HANDLING A FALLING CLIENT



When handling a falling client, pull him/her close to your body and



gently ease him/her to the floor.

7. Evacuation instructions

    a. Clients near fire or smoke must be evacuated first.

    b. Remove ambulatory clients first, then wheelchair clients, and the bedridden clients.

    c. Be able to perform various client carries.

    d. Your primary concern and first responsibility is always the clients' safety.

    e. A staff member must remain with the evacuated client to prevent any of them from re-entering the facility.

8. Remember the first five minutes of a fire are more critical than the next five hours.

9. Remember you must never open windows to get a breath of fresh air.

10. Cover mouth and nose with wet washcloth or towel to reduce smoke inhalation.

11. Never use an elevator during a fire.

III. Tornado Safety

A. The average tornado lasts from eight to ten seconds.

B. Hail often immediately precedes a tornado.

C. Tornado watch

1. Is announced when conditions are such that a tornado may develop

2. Radio and/or television should be on and someone assigned to listen to local station for weather reports.

3. Flashlights should be secured and all staff members made aware of weather conditions.

4. Proceed with the following as requested by the charge nurse:

    a. Clear window sills of all objects; put all heavy, sharp, or glass objects and plants in closets or drawers.

    b. If clients are up in chairs, do not put them back in bed.

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   c. Move bedridden clients into chairs, or put an over-bed table and blanket next to the bed so they can be positioned over the client's face when needed.

   d. Check outside area for loose objects such as chairs, vases, garden tools, etc. and bring them outside.

   e. Open a few windows around the building an inch or two.

D. Tornado Warning

1. Occurs when a tornado has been identified within the local area of a community.

2. Alarms will be sounded.

3. Clear all large rooms (dining room, activities room, etc.) of all clients and staff personnel.

4. Move all clients into hallways near exits or into closets, or away from windows.

5. Bedridden clients may remain in bed--push the bed against the door wall; pull window curtains and privacy curtains. Extra blankets should be applied.

6. Close doors to client rooms securely, close fire doors.

7. Do not block any doorways to hall, fire doors, or exit ways.

8. Cover client in hallways with blankets or bedspreads to protect them from flying glass.

9. Continue to monitor weather reports.

E. After tornado passes

1. Restore calm to clients.

2. Check all clients for injuries and other ill effects.

3. Check for fires throughout the facility.

4. Follow charge nurse's instructions.

IV. Earthquake Safety

A. During an earthquake, the "solid" earth moves like the deck of a ship. The actual movement of the ground, however, is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage, or demolish buildings. Earthquakes may also trigger landslides or cause fires.

B. If an earthquake occurs try to STAY CALM. Think before you act and stay where you are.

1. If inside, stay there; take cover under a heavy object like a desk, table, bench, in a supported doorway, or along an inside wall. Do not use candles, matches, or other open flame either during or after the tremor because of possible gas leaks. (CD-6)

2. If outside, stay there; move away from buildings and utility wires. The greatest danger from falling debris is just outside doorways and close to outer walls. Once in the open, stay there until the shaking stops.

C. After an earthquake

1. Be prepared for additional earthquake shocks.

2. Check for injuries. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.

3. Listen to the radio or television to get the latest emergency information from local authorities.

4. Do not touch downed powerlines or objects in contact with downed lines.

5. Immediately clean up spilled medicines, drugs, flammable liquids, and other potentially hazardous materials.

6. Use the telephone only for genuine emergency calls.

V. Emergency Situations

A. Hemorrhage

1. If client falls and cuts himself/herself and is bleeding in large amounts, follow these steps:

a. Call for help as you go to the client.

b. Apply firm pressure with your hand over the wound, use a clean cloth if available (CD-7)

c. Stay with client until more help comes.

d. If the injury is to an arm or leg, and you can move the arm or leg without causing further injury, raise and compress the bleeding site above heart level to slow down the blood coming to the area.

e. If the client is standing up, assist her/him to lie on a bed, couch, or on the floor so she/he does not faint from blood loss and fall.

f. Do not apply a tourniquet.

g. Follow directions given by the charge nurse.

B. Falls

1. If client falls while he/she is unattended:

a. Call for help immediately

b. Do not move client until the charge nurse has assessed injuries. Be calm, let the client know help is on the way. Stay with the client.

c. Check for swelling, bruising, position change of any extremities, complaint of pain, and accurately report to charge nurse.

d. Assist charge nurse by checking vital signs.

e. Assist charge nurse in moving client--may need as many as four or five people, depending on the size of the client and location of injury. Support client and hold securly when moving.

2. If client falls while attended by a NA: (HO-2)

a. Do not try to prevent the fall, do try to prevent injury.

b. Use your body in the following steps:

(1) Remember body mechanics - feet apart, back straight.

(2) Pull client close to you - hold on to her/him using gait belt or by wrapping your arms around his/her waist or underarms.

LESSON PLAN: 21

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS:

ANSWERS TO EVALUATION ITEMS:

1. a 2. c 3. f 4. h 5. e 6. d
7. g 8. b 9. a 10. F 11. F 12. T
13. T 14. F 15. T 16. T 17. F 18. T
19. T

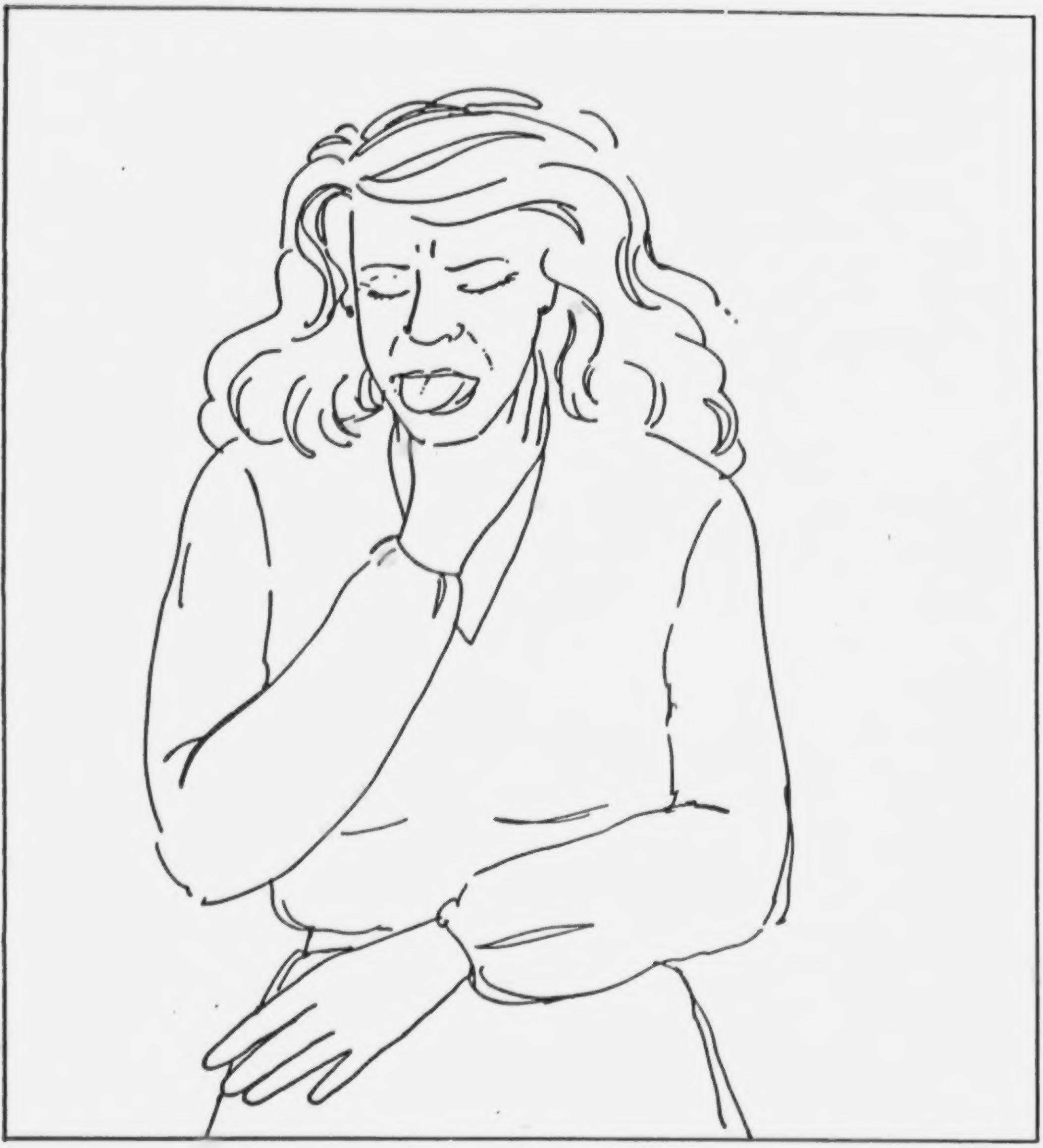
20. Remove Mrs. Taft from her room, closing the door as you leave the room. Take Mrs. Taft to the nearest safe area and call the fire department. Tell the charge nurse (or another employee if the charge nurse is not available) that there is a fire in Mrs. Taft's room. All employees should proceed to their assigned fire stations and begin preassigned duties of closing fire and smoke doors, window, removing additional clients adjacent to the danger area, shutting off mechanical equipment. Return to Mrs. Taft's room with an appropriate fire extinguisher. Before opening the door to enter the room and attempt to extinguish the fire, feel the door. If the door feels warm do not re-enter the room, let the fire department handle it.

21. a. Hemorrhage
    b. Falls
    c. Seizures
    d. Choking

22. Call for help immediately. Be calm, reassure Mrs. Harris and stay with her. Do not attempt to move Mrs. Harris until the charge nurse has assessed injuries. Help the charge nurse with the assessment by checking for swelling, bruising, position change of any extremities, c/o pain; also check vital signs. Assist the charge nurse and others who may be required to help move Mrs. Harris.

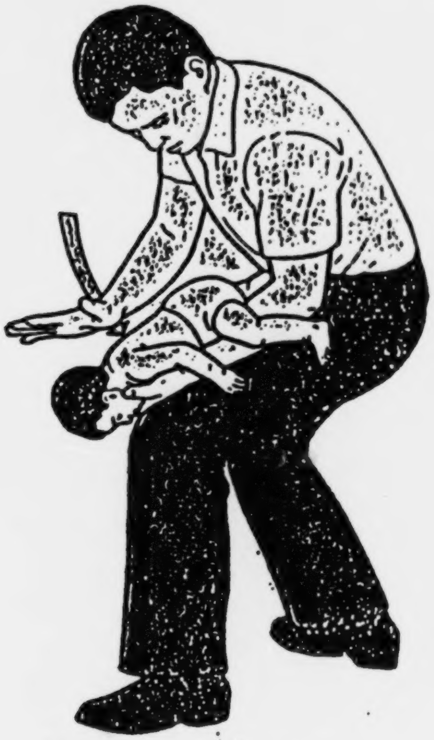
23. c

SIGN OF CHOKING

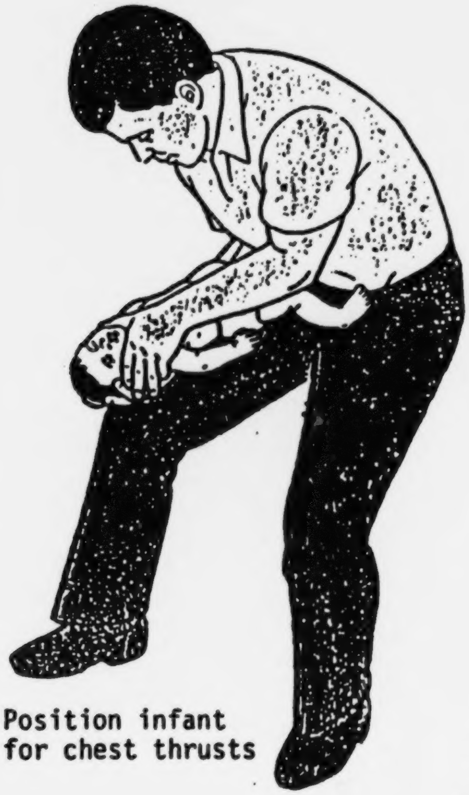


FIRST AID FOR CHOKING: CONSCIOUS INFANT

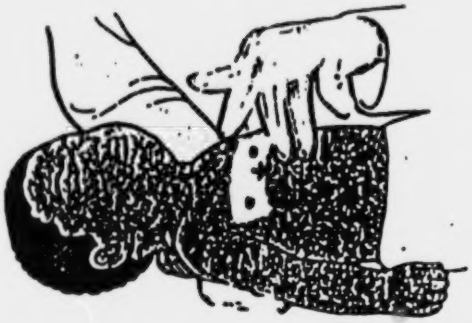
HO 2



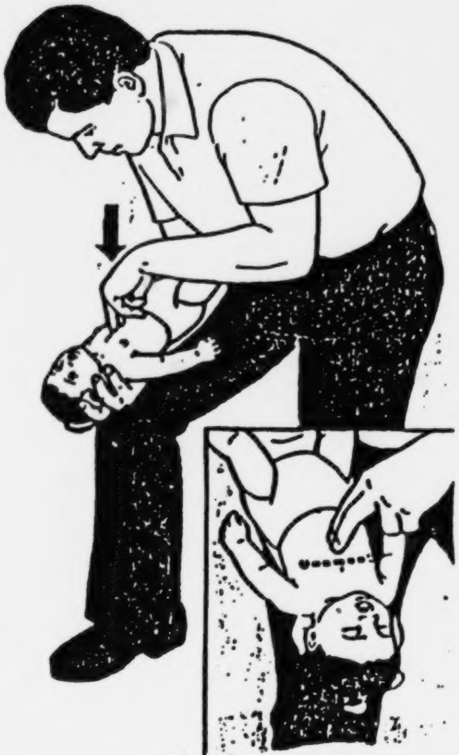
Give four back blows



Position infant
for chest thrusts



Compress breastbone ½ to 1 inch

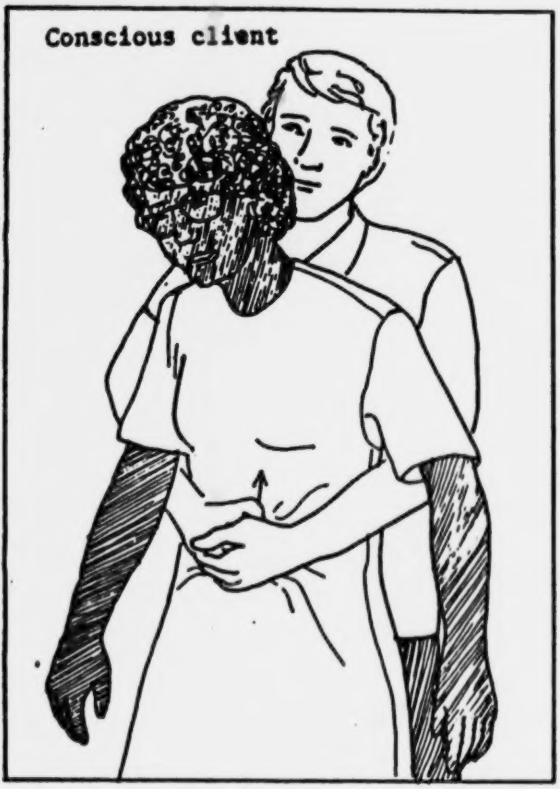


Continue back blows and chest
thrusts until object is expel

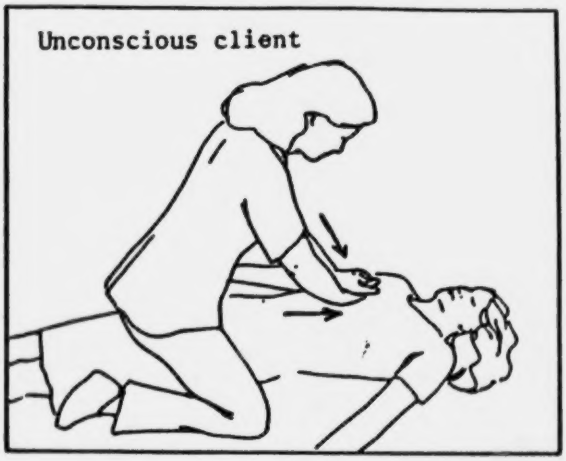
FIRST AID FOR THE CHOKING VICTIM

HO 1

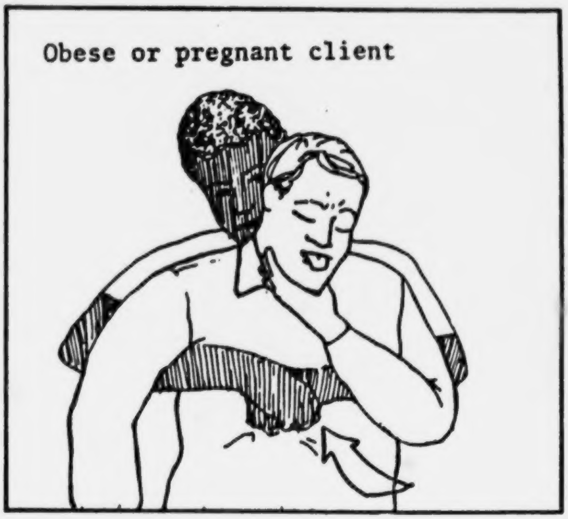
ABDOMINAL THRUSTS



Conscious client

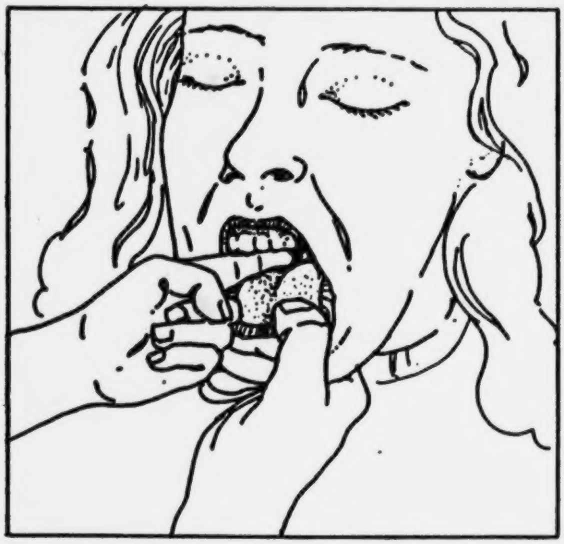


Unconscious client



Obese or pregnant client

MOUTH SWEEP



LESSON PLAN: 23

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: IV-23 OR DEMONSTRATION:

INFECTION CONTROL
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2 Identify three requirements for the growth of microorganisms.
3. List five ways microorganisms are spread.
4. Identify who is considered a susceptible host.
5. Define infection control.
6. List three control measures that prevent the spread of infection.
7. Identify when handwashing should be done.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Body Substance Isolation (Universal Precautions)

IV. Microorganisms That Cause Disease

- A. These microoganisms destroy human tissue by using it as food and produce toxins.
- B. Normal flora may cause disease if our resistance is lowered by stress, illness, or a cut on our skin
    - 1. Example: E. Coli (a bacteria) is normally found in the colon and if it gets into the bladder it may cause a urinary infection. May be transmitted in a variety of ways--no peri care after a BM, improper wiping in females.

V. Conditions Affecting Growth of Mircoorganisms

- A. Food - grow well in remains of food if unrefrigerated
- B. Moisture
    - 1. Damp linens (especially with urine or stool)
    - 2. Water in soap dishes
- C. Warmth
    - 1. Most disease-causing germs grow rapidly between 50 and 110 degrees farenheit.
    - 2. High temperatures (170 degrees Farenheit) kill most germs.
- D. Oxygen - some germs require it to live and some do not
- E. Light
    - 1. Darkness favors growth of germs.
    - 2. Light, especially sunlight, is microorganisms' worst enemy.

VI. How Mircoorganism are Spread (CD-2)

- A. Direct contact
    - 1. Touch
    - 2. All body fluids, discharges and secretions

TEACHER RESOURCES:

INTRODUCTION:

In the previous lesson we discussed the information for recognizing a choking victim and when to start first aid. The following procedure is recommended by the American Red Cross and the American Heart Association. The Heimlich maneuver, also called abdominal thrusts or "bear hugs," can be done in sitting, standing, or supine position. It is now recommended to use only abdominal thrusts rather than back blows and abdominal thrusts. Exclusive use of abdominal thrusts has been found to be more effective and safer. This method is recommended for anyone over one year of age including women in late pregnancy and markedly obese persons.

LESSON PLAN: 22

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

STEPS OF PROCEDURE:

Conscious Victim (HO 1)

A. 1. Ask, "Are you choking?" If the person is coughing weakly or making high-pitched noises or is not able to speak, or breathe or cough forcefully, tell the person that you are trained in first aid for a choking victim. If there is another person nearby, have him or her phone the EMS system for help. Offer your help.

2. Perform abdominal thrusts (Heimlich maneuver). Lock hands together, fingers of one hand curled into those of the other; press the client's abdomen above the navel and below the rib cage with an upward thrust.

3. Repeat thrusts until the obstruction is cleared or until the person becomes unconscious. You should think of each thrust as a separate and distinct attempt to dislodge the object.

4. If unable to get your arms around the waist of some chocking victims, perform chest thrusts. Lock hands together and apply thrust to middle of sternum (breast bone), exert a quick backward pressure to chest.

5. Give thrusts until the obstruction is cleared or until the person loses consciousness. You should think of each thrust as a separate attempt to dislodge the object.

B. Unconscious Adult

The first aid for any unconscious victim begins with the same procedure that you followed in Rescue Breathing in A. R. C. course. While checking the victim, you may find that the victim has an obstructed airway. The procedure for identifying and giving care for an unconscious victim with a complete airway obstruction is presented below.

(These steps are the same initial steps for Rescue Breathing as taught by the American Red Cross.)

1. As you are approaching victim, shout for help.
2. Check the victim for unresponsiveness.
3. Position the victim on his or her back.
4. Open the airway with fingers of one hand under chinbone, and heel of other hand on forehead.

5. Look, listen, and feel for breathing.
6. If the victim is not breathing, pinch nose and try to ventilate.
7. If you are unable to breathe air into the victim, retilt the head and try to ventilate.

If you are still unable to breathe air into the victim, tell someone to phone the EMS system for help

8. Give 6 to 10 abdominal thrusts.
9. Do a finger sweep to try to dislodge and remove the object from the victim's throat. Grasp the tongue and lower jaw with one hand and lift up (pulls the tongue forward and away from back of throat so you can see what is back there). Insert index finger of other hand down along cheek to base of tongue, using a hooking motion; be careful not to push object further down the respiratory tract.
10. Continue abdominal thrusts, finger sweep and ventilations.

C. Conscious Child

For a child who looks as if he or she is choking, but is coughing forcefully, do not interfere with the child's attempt to cough up.

If the cough becomes ineffective and/or there is increased difficulty breathing with a high-pitched noise while inhaling, do the following:

1. Have a bystander phone the EMS system for help.
2. Perform abdominal thrusts until object is dislodged or child loses consciousness.

D. Conscious Infant (Age Newborn to 1 Year) (HO-2)

Because abdominal thrust may cause abdominal injury to infants, a combination of back blows and chest thrusts are used to relieve airway obstruction in conscious infants.

If an infant looks as if he or she is choking and cannot cry, cough, or breathe, shout for help and do the following:

1. Have a bystander phone the EMS system for help.
2. Give four back blows:
    a. Place the infant face down along your forearm, with the head lower than the trunk.
    b. Support the infant's head with your hand by firmly holding the jaw.
    c. Deliver four back blows forcefully between the infant's sholder blades with the heel of your other hand.

3. Then give four chest thrusts:
   a. Place your free hand and forearm along the infant's head and back so that the infant is sandwiched between your two hands and forearms. One hand should be supporting the neck, jaw, and chest from the front, while the other is supporting the back. Turn the infant as a unit on its back. Rest the arm supporting the infant on your thigh.
   b. Give chest thrusts on the breastbone one finger's width below the nipple line.
      Compress the breastbone to a depth of 1/2 to 1 inch four times.
4. Continue giving back blows and chest thrust until the object is expelled or the infant loses consciousness.

E. Unconconscious Infant and Unconscious Child

1. Check for responsiveness.
2. Shout for help.
3. Position the victim.
4. Open the airway.
5. Look, listen, and feel for breathing.
6. Give two breaths.
7. If you are unable to breathe air into the child or infant, retilt the head and attempt to ventilate again.
8. If you are still unable to breathe air into the infant, tell someone to phone the EMS system for help and do the following:
9. INFANT: Give four back blows, then give four chest thrusts. (See D)
   CHILD: Give 6 to 10 abdominal thrusts (See B) using gentle thrust.
   * The child should be positioned face up on his or her back.
   * Place the heel of one hand on the child's abdomen in the midline slightly above the navel and well below the breastbone.
   * Press into the abdomen with quick upward thrust. In small children, perform abdominal thrusts gently.
10. Foreign Body Check: Insert your thumb into the mouth and grasp both the tongue and lower jaw between the thumb and fingers and lift upward. LOOK for the object, and using your small finger attempt to remove it only if you can see it.
11. Continue giving back blows and chest thrusts (Infant) or abdominal thrusts (Child), foreign body check and ventilation until the obstruction is removed or EMS personnel arrive and take over.

SUMMARY AND CONCLUSION:

1. CLASSROOM DISCUSSION

2. REVIEW STEPS OF PROCEDURE

LESSON PLAN: 22

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. Why don't you do thrusts on someone who can speak, cough, or breathe?
2. Why shouldn't you hesitate if the person cannot speak?
3. How do you hold the hands to do the thrusts?
4. When does the procedure stop?
5. What is the first step for the conscious victim?
6. What is the first step for the unconscious victim?
7. Why are backblows and abdominal thrusts given to a choking infant?
8. Why is a mouth check, not finger sweep, done on an unconscious infant with a blocked airway?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. View Film.
2. Demonstrate first aid for the choking victim.
3. Have students practice steps of procedure on each others.

LESSON PLAN: 22

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS: NAME OF STUDENT ______________________

FIRST AID FOR THE CHOKING VICTIM

EQUIPMENT:

DID THE STUDENT	YES	NO
Conscious Victim 1. Call for help as he/she approaches victim.		
2. Check for signs of choking.		
3. Begin abdominal thrusts.		
4. Begin backward chest thrusts for obese victim.		
5. Continue thrusts until obstruction is dislodged or until advanced life support is available.		
Unconscious Victim 1. Call for help as he/she approaches victim.		
2. Check for unresponsiveness and no breathing.		
3. Open airway and ventilate mouth-to-mouth.		
4. If unable to ventitlate, retip head and try again.		
5. Give abdominal thrusts.		
6. If unsuccessful, do mouth sweep.		
7. If unsuccessful, repeat chest thrusts, and mouth sweep.		
8. Continue procedure unitl advanced life support is available.		

The student has satisfactorily completed the procedure "FIRST AID FOR THE CHOKING VICTIM" according to the steps outlined.

____
Instructor's Signature
(Verifying Satisfactory Completion)

____
Date

TEACHER RESOURCES:

INTRODUCTION:

It is necessary that the nurse assistant have a basic understanding of what germs are, conditions that favor their growth and how they are spread. The long-term care facility is not a hospital, but a group living situation where certain routine precautions must be taken regardless of whether infectious illness is present or not.

In the late 1800's, two men made significant discoveries regarding germs. Louis Pasteur found that many diseases are caused by bacteria, and that bacteria could be killed by heat. A few years later, Joseph Lister, a British surgeon, found that germs could be killed by carbolic acid. He introduced the principles of aseptic surgery. Those principles are still followed today and not just in the surgical area. We can control the spread of germs and every staff member must be aware of how this is done.

The techniques discussed in this lesson must be followed for each client in the home setting. The nurse assistant must not bring germs to the client and must keep an infectious client from spreading germs to others in the home.

LESSON PLAN: 23

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

OUTLINE: (Key Points)

I. Terms and Definitions

A. Asepsis - free of disease-causing microorganisms

B. Contaminate - to soil, stain, or pollute

C. Infection - condition in body tissue in which germs have multiplied and destroyed many cells

D. Microorganism - a very small living thing (a germ)

E. Resistance - ability to fight off

F. Sterile - free from all living microorganisms

G. Sanitation - measures taken to reduce the number of contaminants to a level favorable to health

H. Toxin - a poisonous substance

I. Transmitted - transferred or spread

II. Microorganisms

A. Micro means very small

B. Organism means a living thing

C. A mircoorganism is a germ; it cannot be seen by the naked eye

D. Kinds of microorganisms

1. Bacteria
2. Viruses
3. Yeasts and molds (Fungi)
4. Rickettsiae
5. Protozoa

E. Found everywhere in our environment (CD-1)

III. Microorganisms That Are Helpful

A. In the environment, some microorganisms decompose waste or garbage back into useful elements and cause chemical change in food called fermentation.

B. Microoganisms are found living in and on our body. For example, in the digestive tract specific germs help break down food, these germs are called normal flora.

LESSON PLAN: 22

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: OR DEMONSTRATION: IV-22

FIRST AID FOR THE CHOKING VICTIM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate correct technique in providing first aid for a conscious or unconscious choking victim according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: First Aid for the Choking Victim
   HO 2: First Aid for Choking: Conscious Infant
2. Film: "How to Save a Choking Victim--The Heimlich Maneuver".
   Film: "American Red Cross: First Aid", check local Red Cross Chapter
3. Projector or VCR

B. Indirect contact - touching objects contaminated by infected person (such as dishes, linens, clothing, belongings)

C. Droplet spread within three feet - sneezing, coughing, and talking

D. Airborne

1. Dust particle

2. Moisture in air

E. Other sources - contaminated food, drugs, water, or blood (vehicle)

VII. The Susceptible Host

A. A person with low resistance or poor immunity (CD-3)

B. Client

1. Due to aging process, immune system is not as effective at fighting off illness

2. Weakened by illness or disease that is already present

3. Under stress from not being able to function as he or she did in younger years or whose body image has changed.

4. Infant and toddler

C. Co-workers

1. Frequently exposed to disease-causing microoganisms due to nature of the job

2. Poor hygiene habits, such as failing to wash hands at the required times

3. Poor health habits (poor diet, lack of exercise, lack of sleep)

4. Stress from personal problems

VIII. Infection Control

A. This means to prevent the spread of microorganisms that would be harmful to clients and staff.

B. The nurse assistant is responsible for infection control in the following areas:

1. Keep yourself (including uniform and shoes), the client and the environment clean to prevent spread of germs.
2. Be familiar with your facility's isolation techniques and precautions to prevent disease-producing germs from spreading beyond an area.
3. Store, serve and handle food properly to prevent food poisoning.

C. Specific control measures (CD-4)

1. Linen changing
    - a. Keep linen away from your uniform.
    - b. Avoid shaking or fluffing linen.
    - c. Place used linen in a hamper or bag, never on the floor
    - d. Change linen any time it is soiled.
    - e. Keep soiled parts of linen away from everything.
2. Sanitization
    - a. Clean, label, and cover all individual utensils and return to bedside table after each use.

      NOTE: Disposable items should not be reused.
    - b. Return soiled dishes to dietary department after each meal. Damp-wipe overbed tables.
    - c. Each client should have his or her own hygiene supplies and equipment. They should be cleaned regularly and labeled with the client's name.
    - d. Transfer belts should be kept clean.
    - e. When cleaning an item or the body, start with the cleanest area and work toward the dirt area.

3. Disinfection

    a. A process of destroying as many harmful organisms as possible.

    b. See facility's or agency's procedure regarding disinfecting thermometers, utensils, shower chairs, bathtubs, bed frames, mattresses, denture cups.

4. Sterilization

    a. A process that kills all living microorganisms

    b. Requires special processing and handling

5. Handwashing

    a. Our hands carry germs.

    b. Good handwashing technique prevents spread of germs.

    c. When to wash your hands:

        1. When you first come on duty and before going home

        2. Before and after each resident contact

        3. After contact with any wastes or contaminated material

        4. Before any contact with food

        5. After using toilet facilities or smoking

    d. Wash client's hands before meals and at other appropriate times.

    e. Any water faucet is always considered contaminated or dirty.

    f. Turn the faucet off with a paper towel, preferably a dry one.

    g. Use soap from a dispenser if possible, rather than using bar soap. Bar soap accumulates pools of soapy water in the soap dish which is a good medium for germ growth. Rinse bar soap before returning to soap dish.

    h. When washing your hands always hold hands lower than elbows so germs do not contaminate your arms.

6. Universal Precautions (HO-1)

a. Gloves are to be worn when handling feces, urine, wound drainage, oral secretions, sputum, emesis, etc. With newborns, gloves will be worn from delivery until after the first bath and when diapering.

b. Aprons or gowns should be worn if it is likely that your clothing will be soiled with body substances.

c. Masks & goggles will be worn if it is likely that your clothing will be soiled with body substances

d. Laboratory specimens must all be considered as infectious material.

e. Patient charts should not come in contact with infectious material

f. All blood and body substances should always be treated as potentially infectious.

VIII. Summary and Conclusion

A. Terms and definitions

B. Microorganism

C. Microorganisms that are helpful

D. Microorganisms that cause disease

E. Conditions affectng growth of microorganisms

F. How microorganisms are spread

G. The susceptible host

H. Infection control

You should now have a better understanding of germs and the importance of controlling them in the long-term care environment and home. Handwashing is so simple but often neglected. Take the time to protect everyone--yourself, your family, co-workers, the clients and the client's friends and family.

LESSON PLAN: 23

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. Where do you think microorganisms are found?
2. How do you spread germs?
3. What are some reasons why someone would have a low resistance?
4. What kind of things do you do every day at work to control the spread of germs?
5. What are body fluids, secretions, and discharges?

CLASSROOM, LABORATORY OR OTHER ACTIVITIES:

1. Group discussion of classroom discussion questions.

LESSON PLAN: 23

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

______	1. Asepsis	a.	A very small, living thing
______	2. Contaminate	b.	To soil, stain or pollute
______	3. Infection	c.	A poisonous substance
______	4. Microorganism	d.	Transferred or spread
______	5. Resistance	e.	Condition in body tissue in which germs have multiplied and destroyed many cells
______	6. Toxin		
______	7. Transmitted	f.	Free of disease-causing microorganisms
		g.	Ability to fight off

8. Define infection control.

9. List three ways we practice infection control.

   a.

   b.

   c.

10. Microorganisms grow rapidly if conditions are right. Which one of the following slows growth down? (Circle the letter of the correct answer.)

    a. Moisture
    b. Warmth
    c. Sunlight
    d. Darkness

11. Microorganisms are spread by: (Circle the letter of the correct answer.)

    a. Droplets from coughing or sneezing
    b. Direct contact (touching contaminated stool)
    c. Contaminated water or food
    d. All of the above

For each of the following, write "T" if the statement if true, or "F" if it is false.

_______12. Microorganisms are found only in humans.

_______13. An elderly client may have a low resistance due to stress.

_______14. Linen should never be placed on the floor.

_______15. Always clean an item from the dirtiest area to the cleanest.

_______16. Sterilization kills all microorganisms.

_______17. Always wash your hands after coming in contact with contaminated material.

_______18. The water faucet is considered contaminated.

_______19. When washing hands, hold hands above elbows to wash so germs can run down the arms.

LESSON PLAN: 23

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

ANSWERS TO EVALUATION ITEMS:

1. f
2. b
3. e
4. a
5. g
6. c
7. d
8. To prevent the spread of microorganisms that would be harmful to clients, staff, and families.
9. The student may list any three of the following:
    a. Linen changing
    b. Sanitization
    c. Disinfection
    d. Sterilization
    e. Handwashing
10. c
11. d
12. F
13. T
14. T
15. F
16. T
17. T
18. T
19. F

BODY SUBSTANCE ISOLATION (or) UNIVERSAL PRECAUTIONS

All patients will be treated with body substance precautions regardless of their diagnosis.

- * Gloves are to be worn when handling feces, urine, wound drainage, oral secretions, sputum, emesis etc. Also, when it is likely that your hands will touch any moist body substance, mucous membranes, or non-intact skin, wear gloves. With newborns, gloves will be worn from delivery until after the first bath and when diapering.
- * Aprons should be worn if it is likely that your clothing will be soiled with body substances.
- * Masks - goggles - glasses should be worn to protect your eyes and oral/nasal mucous membranes from splashed body substances, such as when suctioning.
- * Needles must never be recapped but discarded uncapped, into puncture-resistance containers along with syringes. Used containers will be secured in Med Rooms. See H.H.A. procedure for needle discard in home.
- * Handwashing before and after client contact is the most important practice to prevent cross contamination among clients and staff.
- * Laundry must be put into plastic bags provided and never sent loose to the sorting room in the laundry.
- * Disposable dishes are not to be used - if client has cafeteria privileges they may use the facility.
- * Patient charts should not come in contact with infectious materials.
- * "Infectious material" stickers will not be used, as all specimens will be considered infectious under this new system and are to be treated the same.
- * Drinking water and containers used to hold water for clients have no special precautions.
- * Dressings and tissues are to be bagged and disposed of in the trash for diaposal in the dumpster for incineration.
- * Urine and feces from clients will be flushed down the toilet to be treated in the municapal sewage treatment system.
- * Perineal pads from menstruating females will be placed in a plastic liner provided and placed in large plastic bag for disposal.
- * Isolation signs will not be used - only Airborne Disease signs will be used when appropriate. Equipment necessary for use will be provided.
- * Use private rooms for clients who soil the environment with body substances.

LESSON PLAN: 24

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: OR DEMONSTRATION: IV-24

HANDWASHING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate correct handwashing technique according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Water
2. Soap
3. Paper towels
4. Wastebasket
5. Hand lotion

TEACHER RESOURCES:

INTRODUCTION:

The procedure for washing hands is extremely important; a basic control of microorganisms depends upon clean hands. Handwashing should be performed at specific times in other procedures and at any other time the health care worker questions the cleanliness of his/her hands. In performing the following procedure, you must remember that you do not turn faucet controls during the procedure; otherwise, you will contaminate your hands from the faucet controls. Keep hands level or lower than elbows to keep surface bacteria from running up the forearm.

LESSON PLAN: 24

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS: NAME OF STUDENT ____________________

HANDWASHING

EQUIPMENT:

1. Water
2. Soap
3. Paper towels
4. Wastebasket
5. Hand lotion

DID THE STUDENT	YES	NO
1. Remove watch and/or rings, roll up sleeves.		
2. Turn on water correctly, adjust temperature.		
3. Wet hands and 2-3" above wrists (keeping wrists lower than elbows).		
4. Apply proper amount of soap (rinse bar soap).		
5. Scrub hands using proper technique on palms, wrists and fingers.		
6. Rinse lower arms, wrists, and hands (keeping wrists lower than elbows).		
7. Dry hands properly.		
8. Turn off faucet correctly.		
9. Discard towel.		
10. Apply hand lotion if desired.		

The student has satisfactorily completed the procedure "HANDWASHING" according to the steps outlined.

____
Instructor's Signature
(Verifying Satisfactory Completion)

____
(Date)

LESSON PLAN: 24

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

STEPS OF PROCEDURE:

1. Remove watch and/or loose rings if necessary. Roll up your sleeves.

2. Turn on water with knee, foot or hand controls; adjust temperature so it is warm.

   CAUTION: Do not turn controls during procedure.

3. Wet hands thoroughly, including two or three inches above wrists; hold hands with wrists lower than elbows.

4. Apply a generous amount of soap to hands. If using bar soap, rinse it well before lathering and before returning it to the dish.

5. Scrub hands for at least 15 seconds:

   a. Wash palms and back of hands with at least ten circular motions.

   b. Wash fingers and between fingers with at least ten circular motion.

   c. Wash wrists and lower arms with at least ten circular motions.

6. Rinse lower arms, wrists, and hands--keep wrists lower than elbows.

7. Dry hands well with paper towel or fresh clean towel, using one for each hand.

8. Turn off faucet with paper towel.

9. Discard paper towel. Be careful not to touch the part that touched the faucet.

10. Apply hand lotion if desired.

SUMMARY AND CONCLUSION:

1. Classroom discussion

2. Review steps of procedure.

LESSON PLAN: 24

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. Why are the faucet controls not turned during the handwashing procedure?
2. Why do we keep our hands lower than our elbows during the handwashing procedure?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Demonstrate handwashing procedure.
2. Divide students into groups to practice and demonstrate handwashing.

LESSON PLAN: 25

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

SCOPE OF UNIT:

This unit covers all areas of safety. It refers to specific measures to be aware of regarding clients, the environment, particular safety devices, as well as the role of the nurse assistant in fire and disaster safety. The prevention and control of infection are also considered safety measures. It is vital to our clients' well-being to prevent communicable diseases in our facilities.

INFORMATION TOPIC: IV-25 OR DEMONSTRATION:

ISOLATION TECHNIQUES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe the purpose of isolation technique.
2. Recognize feelings the client in isolation may experience.
3. Match each type of isolation to the correct reason for its use.
4. Recognize important facts when following isolation procedure.
5. State the definition of terminal disinfection.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Door signs used at facility for different types of isolation.
2. Isolation gown, mask, gloves

TEACHER RESOURCES:

INTRODUCTION:

Isolation is indicated when client has an infection that could be easily spread. The type of isolation is dependent upon what type of infection the client has and how it might be spread. It is important for the nurse assistant to have a basic understanding of the isolation techniques as presented in this lesson.

LESSON PLAN: 25

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

OUTLINE: (Key Points)

I. Purpose of Isolation Technique

  A. This technique is used to prevent the spread of disease-producing germs (pathogens)

    1. Protects the infected client and staff from further infection.

    2. Protects uninfected clients and staff from being infected.

  B. Type of isolation depends upon the type of infection

II. Client's Feelings about Isolation (CD-1)

  A. Client may feel lonely, rejected, or "dirty."

  B. Assist the client in dealing with being in isolation.

    1. Explain to the client the reason for isolation and that this will speed up his or her recovery and prevent the spread of his/her germs which caused the disease.

    2. Check the client at regular intervals so he/she does not feel isolated from the rest of the world. Make sure other staff members know how important is it to check on the client.

    3. Listen to the client's concerns.

    4. Provide assurance to the client.

III. Types of Isolation

  A. Strict isolation

    1. Used to prevent the spread of highly communicable diseases by contact or through the air.

    2. Protects others from the client's germs.

    3. Examples: burn wounds, infections caused by staphylococcus and streptococcus

B. Respiratory isolation

1. Used to prevent spread of disease by droplets that are coughed, sneezed, or breathed into the air.
2. Protects others from the client's germs from respiratory system.
3. Examples: chicken pox, mumps, tuberculosis

C. Wound and skin precautions

1. Used with infections that are spread by coming in direct conduct with wound, linen, or dressing
2. Protects others from germs in client's wounds and heavily contaminated articles
3. Examples: impetigo, infected decubitus ulcers

D. Enteric precautions

1. Used with infections that are spread through urine, feces, and heavily contaminated articles; spread of the infection may involve taking in the germ through the mouth.
2. Protects others from germs in client's bowels, bladder and stomach.
3. Examples: hepatitis, infections caused by diarrhea, AIDS

E. Protective isolation (reverse)

1. Used with persons who have a seriously decreased ability to resist disease
2. Protects client from the germs of other people

(CD-2)

3. Examples: leukemia, burns, client on chemotherapy.

IV. Important Factors

A. Be aware of and follow the measures being taken for each type of isolation.

1. There should be a sign posted that lists all precautions to take with each types of isolation--follow these recommendations listed to protect everyone.

TEACHER RESOURCES:

INTRODUCTION:

Food is very important to all of us no matter what our age. We are what we eat! The whole process of taking in food and producing energy from it is called nutrition. Nutrition becomes extremely important for the long-term care client who may have some impairment in his or her digestive process. The elderly person needs the same nutrition as he/she did at an earlier age, but less calories are required. It is important that we understand the essentials of nutrition in order to provide the clients with the best possible care. In this lesson we will discuss nutrients and their purpose, the basic four food groups, and the most common diets. Essential non-nutrients will also be discussed. So let's eat this lesson up!

2. Gowns, gloves and/or makes may be required for the NA to wear.

3. Gloves must be worn when emptying any fluid-filled container and drainage from urinary bag.

B. Always organize your work before going into the room. (CD-3)

1. Gather all supplies and linens needed.

2. Inform other staff members if you will be needing their assistance.

C. Remember to wash hands before and after contact with the client--this remains the single most important means of preventing the spread of infection.

D. Gloves do not eliminate the need to wash your hands, they just provide a barrier between you and the client.

E. Articles of linens removed from an isolation room must be completely covered with a non-contaminated container; this procedure is called "double bagging."

F. The thermometer and blood pressure apparatus may be left in the room and not taken out of the room until the isolation is discontinued.

G. Terminal disinfection - thorough cleaning of room with disinfectant solution after isolation is discontinued

V. Summary and Conclusion

A. Purpose of isolation technique

B. Client's feelings about isolation

C. Types of isolation

D. Important factors

As a nurse assistant, you must always think in terms of clean and dirty areas. However, your clients in isolation must never feel "dirty" because of your training in isolation techniques.

These techniques help keep you, the client and others free from other infections. Handwashing before and after client contact is the best technique for reducing the spread of infection.

LESSON PLAN: 25

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

CLASSROOM DISCUSSION:

1. How would you feel if left alone in isolation for three or four days with few visitors.

2. If you have experience working in a facility, have you ever taken care of a client in one of these types of isolation? If so, what type of isolation, and what was the experience like?

3. Why is it important to think about supplies you will need before you enter the room?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates how to gown, mask, and glove before entering and leaving strict isolation room.

LESSON PLAN: 25

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

EVALUATION ITEMS:

1. What is the purpose of isolation technique?

For each of the following, write "T" if the statement if true, or "F" if it is false.

______ 2. The client in isolation may feel lonely or dirty.

______ 3. It is only necessary to take care of the isolation client's needs one time each shift.

______ 4. Listening to the client regarding his/her concerns is an important part of his/her nursing care.

______ 5. Gloves eliminate the need to wash your hands.

______ 6. Double bagging is a procedure used to cover contaminated articles when removing them from the client's room.

Match each type of isolation to the correct reason for its use by writing the letter in the blank.

______ 7. Enteric

______ 8. Protective

______ 9. Respiratory

______ 10. Strict

______ 11. Wound and skin

a. Used to prevent spread of communicable diseases by direct contact or through the air

b. Used to prevent spread of disease by airborne droplets

c. Used with infections that are spread by direct contact with wounds

d. Used with diseases spread by body excretions

e. Used with persons who have seriously decreased ability to resist disease

12. Define terminal disinfection.

LESSON PLAN: 25

COURSE TITLE: NURSE ASSISTANT

UNIT IV : SAFETY

ANSWERS TO EVALUATION ITEMS:

1. The purpose of isolation technique is to prevent the spread of disease-producing germs (pathogens) in order to protect the infected resident from further infection as well as to protect uninfected residents and staff from being infected.
2. T
3. F
4. T
5. F
6. T
7. d
8. e
9. b
10. a
11. c
12. Thorough cleansing of room with disinfectant solution after isolation is discontinued.

LESSON PLAN: 26

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: V-26 OR DEMONSTRATION:

NUTRITION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List the five categories of nutrients.
3. List the four food groups and give examples from each.
4. Explain the advantages of six special diets.
5. Identify two methods of providing a nutritionally complete liquid diet.
6. Define non-nutrients and discuss their importance.
7. Discuss the nutritional needs of each age group.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: The Basic Four Food Groups
2. HO 2: General Nutrition
3. HO 3: Basic Food Groups
4. HO 4: Food For All Ages
5. HO 5: Diet for Adults
6. HO 6: Diet for Older Adults
7. Dairy Council Films: "Food, Energy, and You"
   "Food, the Color of Life"
   "What's Good to Eat"
8. Projector/Screen

LESSON PLAN: 26

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

OUTLINE: (Key Points)

I. Terms and Definitions

A. Defecation - passing of stool

B. Digestion - process by which food is broken down, mechanically and chemically, and changed to a form that can be absorbed by the body

C. Nutrient - food that supplies the body with its necessary elements

D. Nutrition - the process of taking in food and producing energy from it

E. Peristalsis - wave-like movements of the digestive tract which push food along to the next part of the intestines

F. Residue - what remains of something after a part is removed

G. Roughage - indigestible fiber of fruits, vegetables and grains which acts as a stimulus to aid intestinal peristalsis

II. Five Categories of Nutrients

A. Protein

1. Function is to build and repair tissue, help build blood, help form antibodies and provide energy
2. If excess protein is taken in, the body will change it to fat and store it as fat.

3. Source - eggs, milk, meat (CD-1)

B. Carbohydrates
   1. Give the body a source of immediate energy

   2. Broken down by digestive process into simple sugars, the most important one is glucose

   3. If excess carbohydrates are taken in, the body will convert them to fat.

   4. Sources - breads, cereals, sugar, syrup, fruits and vegetables and milk (CD-2)

C. Fats

   1. Main function is to store as energy for later use

   2. Sources - butter, cream, salad oil (CD-3)

D. Vitamins

   1. Important for the proper breakdown and use of nutrients

   2. Well-balanced diet contains sufficient amounts

   3. Vitamins may be destroyed by overcooking or exposure to air.

   4. Identified by letters such as A, B-complex, C, D, E, and K

   5. Sources - varies with each vitamin

E. Minerals

   1. Regulate many body processes

   2. Examples - calcium, phosphorus, sodium, iron, iodine

   3. Sources - varies with each mineral

III. Basic Four Food Groups (HO 1, HO 2, HO 3)

- A. A balanced diet contains a particular number of food servings from each of the four food groups. (CD-4)
  - 1. Meat and other protein equivalents
    - a. Meat, poultry, fish, cheese, eggs, dried beans, peas, nuts
    - b. Adult serving: 2 servings = (6 or more ounces/day)
  - 2. Milk and equivalents
    - a. Milk (whole, 2%, skim), yogurt, buttermilk, cream, and cheese
    - b. Adult serving: 2 servings = (2 cups/day)
  - 3. Bread and cereals -
    - a. Enriched or whole grain breads and cereals, crackers, pasta, rice, potato
    - b. Adult serving - 4 servings/day
  - 4. Vegetables and fruits
    - a. Dark-green or deep-yellow vegetables or fruits or fruit juices
    - b. Adult serving - 4 servings/day, 1 vitamin C source daily
- B. The client on a regular diet has no restrictions (HO 4)

IV. Special Diets (HO 5) (CD-5)

- A. Liquid - foods that are liquid
  - 1. Clear liquid

        a. Minimal residue, consists mainly of dissolved sugar and flavored fluids, no milk, not nutritionally adequate alone

        b. Examples: coffee, tea, broth, jello

        c. Usually ordered if resident has flu or diarrhea

    2. Full liquid - intake and output

        a. Strained semi-liquid food, any liquid, can be nutritionally adequate

        b. Examples: fruit juice, milk, pudding, ice cream, creamed soup

        c. Usually ordered is resident has flu or diarrhea

B. Soft

    1. Foods easily chewed

    2. Fibrous and highly seasoned foods eliminated

    3. Examples - tender chopped or ground meat, poultry, well-cooked peeled fruits and vegetables

C. Diabetic - requires closer monitoring

    1. Diet is carefully controlled in kind and amounts of food from the four groups, balance of carbohydrates, protein, and fats

    2. Person lacks insulin which is necessary to break down carbohydrates

    3. Should not have sugar or high carbohydrate foods on tray--check with charge nurse before giving to the resident

    4. May need snacks between meals and at bedtime

    5. Food not eaten should be reported to the charge nurse

D. Bland
    1. Easily digested and low in spices
    2. No roughage (CD-6)
    3. Ordered for clients with ulcers, irritated digestive tracts

E. Low salt (low sodium)
    1. Salt occurs naturally in food, this diet eliminates salty food and salt added to food
    2. Sodium is a mineral that helps regulate the body's water balance
    3. No table salt on tray or table
    4. Check with charge nurse before giving resident a salt substitute. (High K+)

F. Low cholesterol - eliminates animal fats from diet, allows some types of vegetable fats

IV. Nutritionally Complete Liquid Diets

A. Oral
    1. Given by mouth for client to drink (CD-7)
    2. May be a supplement to regular diet or may be the only nutrition the resident takes in
    3. May be commercially prepared, such as Ensure or Sustagen
    4. May be prepared by dietary department

B. Tube feedings
    1. Given by a tube inserted into the nose that goes down the esophagus into the stomach (NG tube) or by a tube that goes directly into the stomach (gastrostomy tube); head of bed is elevated during administration; intake and output is recorded

2. May be a supplement to regular diet or may be the only nutrition the client takes in

3. May be commercially prepared

4. May be prepared by dietary department

V. Non-Nutrients

A. Fiber

1. The non-nutritive part of plant food--the indigestible part

2. Provides bulkiness to the stool--the larger and softer stool is, the easier it is to eliminate, thus preventing constipation

   NOTE: See lesson 45 for more detailed information pertaining to conditions that cause abnormal bowel function.

3. Sources - whole wheat, bran, outside of corn kernels and peas, fruit and potato skins

B. Water

1. Essential to life - a person can only live a few days without water, provides minerals but no other nutrients

2. 60% of the human body is water.

3. Fluid intake must match what is lost by urination, defecation, perspiration, respiration, vomiting, drainage from wounds, hemorrhage, and extensive burns.

4. Illness may upset water balance.

5. Dehydration is an excessive loss of water from body tissues; symptoms may include thirst although the elderly often do not get "thirsty" which is why water should be offered frequently;

other symptoms are dryness of skin and mucous membranes (inside of nose and mouth), constipation, little or no urination, fall in BP, loss of tissue elasticity, dizziness and mental confusion

6. Edema occurs when there is too much fluid in the tissue. Symptoms include swelling, shortness of breath, increase in weight, decrease in urine. (CD-8)

VI. Nutritional Needs of the client (CD-9)

A. Food for All Ages (H.O. 4) (Teach from this handout)

1. Nutritional needs of the elderly are the same as for a middle-aged adult except for a reduction in calories, due to not being as physically active.

2. Fats, desserts, and sweets should be served in smaller amounts to avoid excess calories.

3. If appetite is poor, offer smaller, more frequent meals.

VII. Summary and Conclusion

A. Terms and definitions

B. Five categories of nutrients

C. Basic four food groups

D. Special diets

E. Nutritionally complete liquid diets

F. Non-nutrients

G. Nutritional needs of the client

You should now have an understanding of the importance of diet for the clients as well as for yourself. If nutritional needs are not being met, problems will arise. Take note of the food you serve to the clients and how it fits into a well-balanced diet. Also note what foods you should encourage the client to eat.

LESSON PLAN: 26

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. Name some foods that are high in protein.
2. What are some examples of foods that are high in carbohydrates?
3. What are some examples of foods that are high in fats?
4. What foods are included in these groups?
5. Have you ever been on a special diet?
6. What is meant by roughage?
7. Have you ever tasted any commercially prepared liquid diets?
8. Do you know how fiber and water help prevent constipation?
9. Do the elderly clients' nutritional needs differ from yours?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Assign students to keep a food intake chart for one day and classify foods in each food group.
2. Have guest dietician speak to class on nutritional needs of the adolescent and older adult.
3. Show films

LESSON PLAN: 26

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

EVALUATION ITEMS:

Match each term to the correct definition.

______ 1. Defecation

______ 2. Digestion

______ 3. Nutrient

______ 4. Nutrition

______ 5. Peristalsis

______ 6. Residue

______ 7. Roughage

a. Process by which food is broken down, mechanically and chemically, and changed to a form that can be absorbed by the body

b. What remains of something after a part is removed

c. The process of taking in food and producing energy from it

d. Food that supplies the body with its necessary elements

e. Indigestible fiber of fruits, vegetables, and cereal which acts as a stimulus to aid intestinal peristalsis

f. Wave-like movements of the digestive tract which push food along to the next part of the intestines

g. Passing of stool

8. List the five categories of nutrients.

a.

b.

c.

d.

e.

9. List the four basic food groups and an example from each one.

a.

b.

c.

d.

10. How do the elderly clients' nutritional needs differ from that of a middle-aged adult?

For each of the following, write "T" if the statement is true, or "F" if it is false.

______11. On a clear liquid diet, the client may have milk.

______12. On a regular diet, the client may have any food he or she desires.

______13. The soft diet is easily digested and chewed.

______14. For a bland diet, the food is highly seasoned.

______15. Salt is necessary for a low sodium diet.

______16. The diet of a diabetic must be carefully controlled.

______17. Water is vital to all body functions.

______18. Liquid tube feedings may be given to provide the same nutrition as a well balanced regular diet.

______19. Fiber is the nutritive part of plant food which is easily digested.

LESSON PLAN: 26

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

ANSWERS TO EVALUATION ITEMS:

1. g
2. a
3. d
4. c
5. f
6. b
7. e
8. a. Carbohydrates
   b. Fats
   c. Protein
   d. Vitamins
   e. Minerals

9. a. Meat and other protein equivalents - the student may list any one of the following as an example: meat, poultry, fish, cheese, eggs, dried beans, peas, nuts

   b. Milk and equivalents - the student may list any one of the following as an example: milk (whole, 2%, skim), yogurt, buttermilk, cream, cheese

   c. Breads and cereals - the student may list any one of the following as an example: enriched or whole grain breads and cereals, crackers, pasta, rice, potato

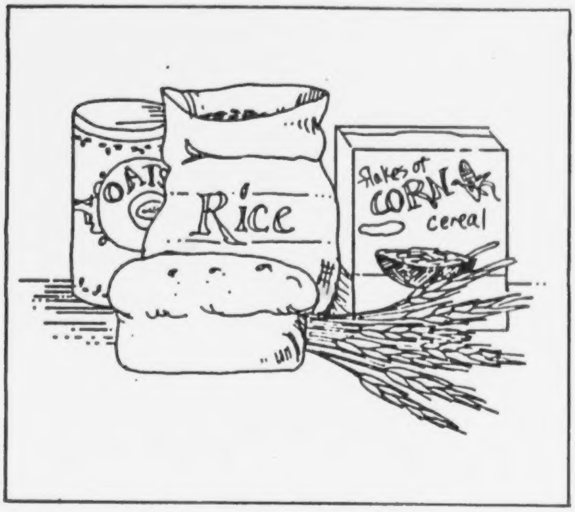
   d. Vegetables and fruits - the student may list any one of the following as an example: dark green or deep yellow vegetables

10. The nutritional requirements are the same, but fewer calories are needed due to decreased physical activity.

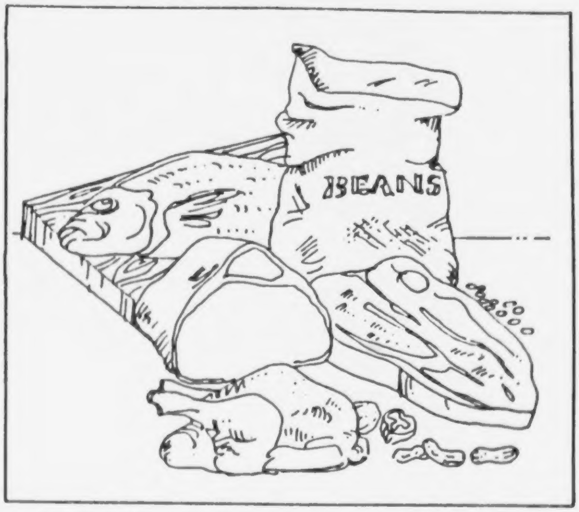
11. F
12. T
13. T
14. F
15. F
16. T
17. T
18. T
19. F

THE BASIC FOUR FOOD GROUPS

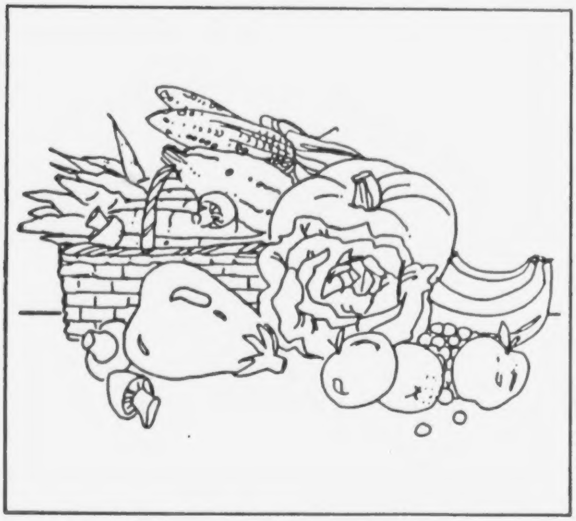
HO 1


OATS
Rice
flakes of
CORN
cereal

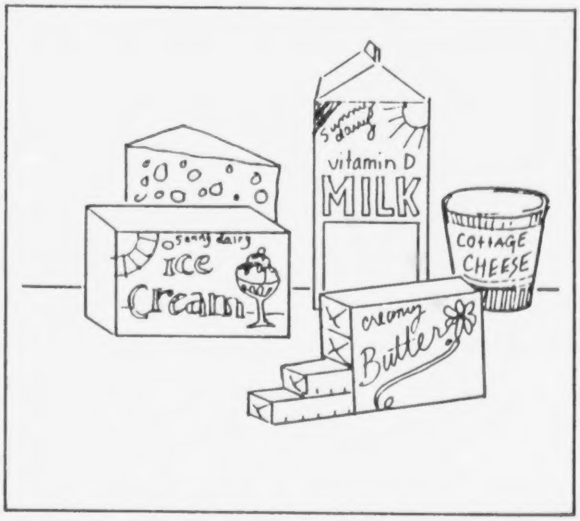
BREADS AND CEREALS
4 Servings/Day



MEAT AND OTHER PROTEIN EQUIVALENTS
6 or More Ounces/Day



VEGETABLES AND FRUITS
4 Servings/Day


Sunny dairy
vitamin D
MILK
COTTAGE
CHEESE
sunny dairy
ICE
Cream
creamy
Butter

MILK AND EQUIVALENTS
2 Cups/Day

GENERAL NUTRITION

The body depends on food for energy, growth, repair of tissue, and the maintenence and regulation of many functions. Each nutrient furnished by food has a specific contribution to good health. The use of any one nutrient by the body is dependent on a proper balance of all the other nutrients to accomplish its purpose. The more variety there is in the choice of food, the better the diet is likely to be.

Energy needs must be met to maintain a healthy body. Food energy values and allowances are expressed in Kilo-Calories and will be referred to as calories throughout this manual. The energy allowance for each population and age group varies. The average needs of people in each category is expressed in the Recommended Dietary Allowance (RDA) Table.

It is important to maintain desirable body weight throughout life and this is done through a balance between energy intake and energy output. A large number of individuals in the United States are overweight and may require less energy than is recommended because they have sedentary work and leisure patterns. Energy intake should be adjusted for the individual to maintain desirable body weight in relation to age, sex, height and physical activity.

Energy may be derived from any reasonable combination of carbohydrate, fat and protein. An additional source of energy is alcohol.

Carbohydrate

Carbohydrate is the main source of energy in the diet. A reasonable proportion, 45-55 percent, of a person's caloric intake should be derived from carbohydrates. Foods such as fruits, vegetables and whole-grain cereals provide energy mainly from carbohydrate and are generally good sources of other nutrients, such as vitamins and minerals. The principal carbohydrates are sugars, starches and cellulose. The sugars include the monosaccharides and disaccharides in refined sugars, jams, jellies, syrups, honey, fruits, soft drinks and milk. The starches are the polysaccharides of cereals, flour, potatoes, and other vegetables. Dietary fiber is generally defined as the sum of the indigestible carbohydrate and carbohydrate-like components of food, including cellulose, lignin, hemicelluloses and pectins.

Fat

Another source of energy in the diet is fat. Dietary fat also serves as a carrier for fat-soluble vitamins and provides essential fatty acids. Total fat intake should comprise no more than 35 percent of dietary energy. Food sources of fat include butter, margarine, oils, lard and fat in meat, poultry, fish, and dairy products. Essential fatty acids, the primary one being linoleic acid, must be provided in the diet because of the multiple functions they perform. Linoleic acid is found widely in varying amounts in foods of both plant and animal origin.

Protein

Another important component in the diet is protein. Protein foods can be used as an energy source but more importantly, food proteins provide amino acids for the synthesis of body proteins and for the synthesis of many other tissue constituents. Amino acids obtained from food proteins are essential for growth. Nine essential amino acids are not synthesized by the body and therefore must be provided by foods in the diet. Animal products--eggs, milk, meat, fish and poultry--contain all of the essential amino acids in the correct proportion. Grains and legumes also furnish protein but are low in some essential amino acids.

Vitamins and Minerals

Vitamins and minerals serve many functions. Vitamins are a group of organic compounds in foods that are needed in minute quantities, and are essential for specific body functions of maintenance, growth and reproduction. Vitamins are classified as either fat soluble or water soluble. Minerals are subdivided into two categories: 1) macro-nutrients--those occuring in appreciable amounts accounting for most of the body content of minerals such as calcium--and, 2) micronutrients or trace elements--those present in minute quantities, such as iodine or iron. Mineral elements are components of the body's structure or constituents of enzymes and hormones. They serve as regulators of body fluids and are involved with other body functions.

Fiber

A normal, healthy diet should contain 20-25 grams of dietary fiber. Dietary fiber is generally defined as the sum of the digestible carbohydrate and carbohydrate-like components or food including cellulose, lignin, hemicelluloses, pentosans, gums, and pectins. These nondigestible substances provide bulk in the diet and aid elimination. (See Appendix)

Water

Water is an essential part of the diet for it plays a role in practically all body processes, and is the most abundant body constituent. The body is equipped with a number of homeostatic mechanisms, including the sensation of thirst, that operate to maintain total body water within narrow limits. Water is present in practically all foods.

Food groupings have been made and general guidelines established which recommend the appropriate number of servings from each of the food groups, so that an adequate amount of minerals and vitamins are provided in the daily diet. The elimination of one food group might appreciably reduce the intake of one or more of the minerals and vitamins.

The manner in which foods are selected, prepared, and served affects their contribution to the diet. Care must be taken to select a variety of foods, prepare them in a manner to preserve their nutrient content, prevent food spoilage or contamination, and serve them attractively.

Source: Missouri Diet Manual, 6th Edition, Missouri Department of Health and Missouri Department of Social Services - Division of Aging

BASIC FOOD GROUPS

The food groups provide a pattern to use as a guide when planning menus. The minimum number of servings specified from each group, if well chosen, forms the foundation of a nutritionally adequate diet. Use of additional servings from these groups along with the "other" foods may be needed if caloric need is greater.

MEAT AND MEAT ALTERNATES

The meat group includes meat (beef, veal, pork, lamb and wild game); fish and shellfish; poultry; eggs; and legumes such as dry beans, lentils and nuts.

A serving from this group equals:

2 ounces meat, fish or poultry
1/2 cup canned tuna or salmon
2 eggs
2-3 ounces of liver
2 hot dogs, 1 3/5 ounces each
3-4 slices luncheon meats, 1 ounce slices
4 tablespoons peanut butter
1/2 cup nuts
1 cup of cooked dried beans, peas or lentils

Meat, fish poultry and eggs provide high quality protein. Dry beans and peas, soy extenders, and nuts by themselves are incomplete proteins (amino acids). Foods containing dry beans, dry peas or nuts should be combined with grain or animal protein to enhance protein utilization (examples: bean burrito with cheese and peanut butter sandwich). This group also supplies fat, iron, niacin and other nutrients.

MILK AND MILK PRODUCTS

The milk group contains all types of milk used as beverages, all kinds of natural or processed cheese, cottage cheese, yogurt, ice cream and foods made with large proportions of milk such as cream soups and puddings.

The recommended servings of milk vary for different groups of people because nutrient needs vary with body size and the stage of growth.

A serving from this group equals:

1 cup or 8 ounces whole, 2% or skim milk, buttermilk; reconstituted nonfat dry or reconstituted evaporated milk
1 1/2 ounces cheese
2 ounces cheese spread
1 1/3 cups cottage cheese
1 1/2 cups cream soup made with milk
1 1/2 cups ice cream
1 cup pudding or custard made with milk
1 cup yogurt

Milk is the best source of calcium and riboflavin, and is an important source of vitamins A and D and high quality protein. Milk provides carbohydrate, fat (unless nonfat milk is used), and other nutrients.

BREADS AND CEREALS

The bread and cereal group includes all grains--such as barley, buckwheat, corn, oats, rice, rye and wheat--and bread, breakfast cereals, grits, noodles and pasta products made from grains.

Each of the following is equal to one serving from the bread and cereal group:

1 slice whole-wheat or enriched bread
1 pancake or small waffle
1 tortilla
1/2 English muffin or hamburger bun
3/4 cup ready-to-eat cereal
1/2 cup cooked cereal, rice grits, pasta or noodles
1 roll, muffin or biscuit
4 saltines
2 graham crackers
1 piece (2" square) cornbread

Labels should be checked carefully to assure that the products are enriched fortified or whole-grain. Enriched grains provide iron, thiamin, riboflavin and niacin, and are the main source of carbohydrate. Whole-grain foods, such as whole-wheat bread, oatmeal and shredded wheat, provide more fiber, zinc, folic acid and vitamins B6 and E than other bread and cereals. Milk combined with grains improves the usuability of grain proteins for body repair and building. (Examples: cereal with milk; cheese and rice casserole.)

FRUITS AND VEGETABLES

The fruit and vegetable group includes all fresh, frozen and dried fruits and vegetables except dried beans and peas. A daily source of vitamin C and a folic acid rich food needs to be included in the diet. A rich source of vitamin A is needed at least 3 to 4 times per week.

A serving of cooked fruits and vegetables is equivalent to 1/2 cup or a portion ordinarily served, such as a medium apple or banana, a potato or half of a medium grapefruit. The serving size should be increased to 1 cup for raw vegetables, such as dark green leafy vegetables.

Fruit and Vegetable Group	Serving and Food
Vitamin C Source	
Citrus Fruits	1/2 cup orange or grapefruit juice 1/2 grapefruit 1 medium orange 2 small tangerines
Other Fruits	1/4 cantaloupe 1/2 cup strawberries 1/2 cup fruit juice enriched with vitamin C
Vegetables	1 stalk broccoli 1 1/2 cups cabbage 3/4 cup cauliflower 1/2 medium green or red pepper 2 medium tomatoes 1/2 cup brussels sprouts

Fruit and Vegetable Group	Serving and Food
Folic Acid and Vitamin A	1 cup raw or 3/4 cup cooked broccoli; asparagus; brussel sprouts; spinach, beet, mustard, or turnip greens; dark leafy lettuce.
Vitamin A Sources	1/2 cup servings of apricots, cantaloupe, carrots, pumpkin, sweet potatoes, tomatoes, winter squash, greens.
Other Fruits and Vegetables	1/2 cup cooked green beans, potatoes, beets, etc. 1 medium peach, apple, etc.

FATS AND OILS

Fats are a concentrated source of energy, contain essential fatty acids, and serve as carriers for fat-soluble vitamins.

A serving equals:

1 teaspoon margarine, butter or oil
1 tablespoon salad dressing or cream cheese
1 tablespoon sour cream or heavy cream
1 teaspoon mayonnaise
1 slice bacon
1 tablespoon gravy

OTHER

This group contains foods which have a low nutrient density (a low level of nutrients and a high calorie content).

Foods included in this group are sweets or desserts which are high in fat and sugar, and are often made with unenriched flour. Salty items, such as potatochips and salt pork, are included in this group. These foods can compliment, but do not replace, foods from the four food groups. Amounts or servings should be determined by individual calorie needs.

BEVERAGES AND FLUIDS

This group supplies no significant nutrients, but does supply water. Coffee,tea and sugar-free carbonated beverages are contained in this group. Carbonated and alcoholic beverages provide carbohydrate and alcohol, and may contribute significant calories.

MISCELLANEOUS

Items contained in this group include condiments and sweets which are used in small amounts. Condiments or flavoring substances, such as catsup or mustard, may contribute some nutrients but are usually eaten in amounts too small to be significant. Sugar, honey, syrup, jam or jelly contain little or no additional nutrients other than carbohydrate.

MEAN HEIGHTS AND WEIGHTS AND RECOMMENDED ENERGY INTAKE[a]

Category	Age (years)	Weight (kg)	Weight (lb)	Height (cm)	Height (in)	Energy Needs (with range) (kcal)	(MJ)	
Infants	0.0-0.5	6	13	60	24	kg x 115	(95-145)	kg x 0.48
	0.5-1.0	9	20	71	28	kg x 105	(80-135)	kg x 0.44
Children	1-3	13	29	90	35	1300	(900-1800)	5.5
	4-6	20	44	112	44	1700	(1300-2300)	7.1
	7-10	28	62	132	52	2400	(1650-3300)	10.1
Males	11-14	45	99	157	62	2700	(2000-3700)	11.3
	15-18	66	145	176	69	2800	(2100-3900)	11.8
	19-22	70	154	177	70	2900	(2500-3300)	12.2
	23-50	70	154	178	70	2700	(2300-3100)	11.3
	51-75	70	154	178	70	2400	(2000-2800)	10.1
	76+	70	154	178	70	2050	(1650-2450)	8.6
Females	11-14	46	101	157	62	2200	(1500-3000)	9.2
	15-18	55	120	163	64	2100	(1200-3000)	8.8
	19-22	55	120	163	64	2100	(1700-2500)	8.8
	23-50	55	120	163	64	2000	(1600-2400)	8.4
	51-75	55	120	163	64	1800	(1400-2200)	7.6
	76+	55	120	163	64	1600	(1200-2000)	6.7
Pregnancy						+300		
Lactation						+500		

[a] The data in this table have been assembled from the observed median heights and weights of children, together with desirable weights for adults given for the mean heights of men (70 in.) and women (64 in.) between the ages of 18 and 34 years as surveyed in the U.S. population (HEW/NCHS data).

The energy allowances for the young adults are for men and women doing light work. The allowances for the two older age groups represent mean energy needs over these age spans, allowing for a 2 percent decrease in basal (resting) metabolic rate per decade and a reduction in activity of 200 kcal/day for men and women between 51 and 75 years, 500 kcal for men over 75 years, and 400 kcal for women over 75 years. The customary range of daily energy output is shown in parentheses for adults and is based on a variation in energy needs of ± 400 kcal at any one age, emphasizing the wide range of energy intakes appropriate for any group of people.

Energy allowances for children through age 18 are based on median energy intakes of children of these ages followed in longitudinal growth studies. The values in parentheses are 10th and 90th percentiles of energy intake, to indicate the range of energy consumption among children of these ages.

SUGGESTED DESIRABLE WEIGHTS FOR HEIGHTS AND RANGES FOR ADULT MALES AND FEMALES

Height[a]		Weight[b] Men				Women			
in.	cm	lb.		kg		lb.		kg	
58	147					102	(92-119)	46	(42-54)
60	152					107	(96-125)	49	(44-57)
62	158	123	(112-141)	56	(51-64)	113	(102-131)	51	(46-59)
64	163	130	(118-148)	59	(54-67)	120	(108-138)	55	(49-63)
66	168	136	(124-156)	62	(56-71)	128	(114-146)	58	(52-66)
68	173	145	(132-166)	66	(60-75)	136	(122-154)	62	(55-70)
70	178	154	(140-174)	70	(64-79)	144	(130-163)	65	(59-74)
72	183	162	(148-184)	74	(67-84)	152	(138-173)	69	(63-79)
74	188	171	(156-194)	78	(71-88)				
76	193	181	(164-204)	82	(74-93)				

a Without shoes.
b Without clothes. Average weight ranges in parenthesis.

Reprinted from Recommended Dietary Allowances Ninth Edition, National Academy of Sciences, Washington, D.C., 1980, by permission.

FOOD FOR ALL AGES

HO 4

(From General Foods Booklet prepared by the U.S. Departments of Agriculture and Health, Education and Welfare)

Regardless of age, everyone needs the same nutrients but often in different amounts. People doing hard physical labor need more energy than those who are less active. Women need more iron than men.

The six-footer needs more food than a little person; the steelworker more than the clerk. When a patient is on the mend from an illness, he may need more nutrients than when he is in good health.

One thing is certain: nutrition affects everyone from the day he is born, actually even before he is born.

Nutrients for the unborn child's growth and development come from the mother, which means that her diet during pregnancy is especially important.

While parents guide their children to good eating habits they might take a good look at their own food attitudes. If the food they don't like is never served, then the family will never get a chance to eat it regardless of how nutritious it might be.

Changing poor food habits is usually harder than starting out with good food habits, but it can be done.

The parents' example will teach children to eat foods that are not their favorites, usually without the children ever even thinking about it.

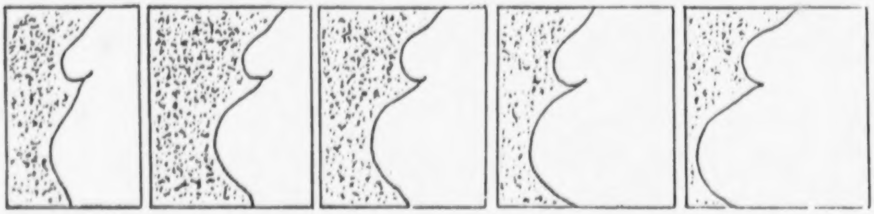
The more foods people learn to enjoy, particularly among the fruits and vegetables, the easier it will be for them to change their diets if it becomes necessary because of health problems, military service, foreign travel or some other reason.

Of course, somewhere along the road to a healthy old age, you learn that you must fit your diet to the amount of energy you use.

Regular exercise, like proper food, is a vital factor in continuing good health.

BEFORE BIRTH.

The woman who reaches child-bearing age well nourished and who maintains a good diet during pregnancy is more likely to have a healthy pregnancy and a healthy baby than the woman whose diet is poor.



But pregnancy can be a problem, particularly when expectant mothers are still teenagers. The body must cope with its own growth needs as well as the needs of the baby. A young girl—17 years or younger—who is in less than the best of health when she becomes pregnant, is borrowing trouble for herself and lending it to the child she carries.

And it is not just the poverty-stricken teenager who faces such problems.

Many a woman with enough money for a good diet copes with pregnancy in a state of semi-starvation because of the cult of slimness.

Pregnancy for an older woman can also be a hazard if her body stores of nutrients are already depleted by numerous pregnancies.

A woman who has always eaten well will not, ordinarily, have to make many changes in her diet because of pregnancy.

A daily diet during pregnancy should include at least two servings of lean meat, fish, poultry or eggs; four or more servings of vegetables and fruits including some which are good sources of iron, vitamin A and vitamin C; four servings of enriched or whole-grain breads or cereals and three or more cups of milk. Some of the milk and other foods such as margarine may be fortified with the vitamin D which is needed during pregnancy.

These foods provide the extra proteins, vitamins and minerals needed to maintain the expectant mother's body and for the baby's growth.

It may be hard to get all the iron and folic acid needed through food alone and the doctor will often prescribe a supplement to supply them.

Healthy women usually gain an average of 24 pounds during pregnancy.

Pregnancy is certainly no time to try to lose weight; there will be time enough for that later. If a mother decides to nurse her baby, she should continue to include foods which will give her more protein, vitamins, minerals and calories.

A pint of milk and an egg added to a diet which was nutritionally adequate before pregnancy will provide all the additional protein and almost half of the vitamin A needed. Using milk as the source of extra protein also contributes to the mother's need for fluid when nursing.

The continued use of the green vegetables and fruits recommended for pregnancy will supply most of the other minerals and vitamins needed.

THE INFANT.

A child grows and develops more rapidly during the first few years of life than at any other time. Thus good nutrition is especially important. Feeding does more than nourish the infant's body, it also can help a child to establish warm human relationships with parents and other persons.

Milk is the baby's first food—milk either from the mother's breast or from a bottle. Since milk supplies a large proportion of the nutrients needed during the first two years of life, the choice of kind of milk or formula must be made with care.

Human milk is custom-made for the baby, is clean as it comes from the breast, can save a lot of work, and can be a satisfying experience for both mother and baby.

Human milk will ordinarily supply adequate amounts of all of the essential nutrients during the first few months of life with the exception of vitamin D, fluoride and iron.

If a commercially prepared infant formula, evaporated milk or homogenized whole milk is used, it will usually have vitamin D added to it. If not, then the baby will need to be given a vitamin D supplement.

The baby needs vitamin C early in life. Human milk and commercially prepared infant formulas usually provide adequate amounts of vitamin C.

If the baby is being fed evaporated milk or cow's milk formula, then vitamin C should be given in the form of drops. Otherwise a fresh, frozen or canned fruit juice that is naturally rich in vitamin C or fortified with vitamin C can be used.

A source of iron should also be added to the infant's diet early in infancy. Unless the baby is receiving iron-fortified formula, the doctor may suggest using an iron-fortified infant cereal or medicinal iron, beginning between 1-2 months of age.

Whether or not a fluoride supplement is given to the infant will depend upon how much water the infant takes and the amount of fluoride in the water supply of the area.

Solid foods, such as cereals, strained fruits and vegetables, may be added by 1 to 3 months of age. Gradually other foods such as egg yolk, strained meat and fish are added. Be careful in choosing commercially available strained foods for baby; there are wide variations among them in the amount of calories and other essential nutrients.

By the time the baby is six months old, he or she will be receiving some "table food." When 7-9 months old, a baby is usually ready for foods of coarser consistency–chopped or junior foods. By then he or she will likely be on three meals a day with mid-morning and mid-afternoon snacks.

PRE-SCHOOL.

During the second and third years of life, the child grows much less rapidly than during the first year. Little children still need foods that help them grow and provide the energy they need.

The diet started in infancy should be continued with larger servings of meat, fish, and eggs, as well as fruits and vegetables, plenty of milk and whole grain cereals and bread. Children in this country often get less vitamin A than they need.

Parents need to try especially hard to include dark green and yellow vegetables such as broccoli, collards, kale, carrots, sweet potatoes and winter squash in children's meals. Butter and fortified margarine also supply generous amounts of vitamin A.

Children may be short of vitamin C, because they do not eat enough citrus fruits or juice, tomatoes, raw cabbage or other foods which are rich sources of that vitamin.

Fortified milk is a good source of vitamin D. The child who drinks less than one pint of milk a day may need a supplemental supply.

Preschool children may need snacks to tide them over to the next meal.

Some well chosen snacks are milk, small pieces of fruit, cut-up raw vegetables, cheese cubes, crackers spread with cottage cheese or peanut butter, and cereals.

Pick snacks that carry their weight in food value—don't let sweets become the rule.

Children should be served small-sized portions and come back for "seconds" if necessary. Some children get fat because they are taught to eat more than they need, even as infants. It is possible that the habit of overeating in infancy and early childhood may continue to obesity in later years.

BETWEEN TODDLER AND TEEN.

The elementary school child needs the same kind of foods the preschooler does, but, perhaps, larger servings.

Going to school, however, calls for a routine and a schedule. The preschool child can play for a while until he or she feels like breakfast. Not so the school child; there are carpools, buses and school bells to be coped with.

Going to school may be the beginning of the child's independence in choosing food. The child may need help in learning how to make wise choices.

If the elementary school child is getting too plump, take a good look at the amount of exercise he is getting and at what and how much he is eating.

THE PERILOUS TEENS.

There are two good reasons for concern about the food habits of teenagers. Teenagers are casting off the habits of childhood while still trying to find their own identities. As a result, good food habits may be lost for a while.

One out of every four mothers has her first child when she is less than 20 years old. The teenage appetite is often huge, but appetite alone is not enough to insure that the teenager will get all of the nutrients he or she needs.

During their teens, boys and girls grow at a faster rate than at any other time except in infancy. A boy's nutritional requirements during the time he is becoming a man are higher than at any other time in his life.

Those of a girl becoming a woman are exceeded only during pregnancy and lactation (the period following birth when the mother's breasts are manufacturing milk). So, a pregnant teenage girl has even greater nutrient needs.

A teenage boy may suddenly shoot up as much as four inches in height and gain 15 pounds in weight in a year.

A teenage girl's total gain is not usually so large, but it is considerable.

Growth involves more than increases in height and weight alone. Body fat is lost while bones increase in density and muscles develop in size and strength.

The endocrine glands—the glands that manufacture, or secrete, hormones, the chemical substances that control many body processes—are growing and developing.

The teen years are also a period of stress—physical and mental.

Teenage eating habits are often bad and the reasons are not hard to find: school, clubs and part-time jobs keep teenagers away from home at mealtime.

Their eating habits are being influenced by friends more than by parents.

Some skip breakfast because they don't leave enough time for it. Some choose snacks that are too rich with fats and sugar.

Teenage girls sometimes eat too little because they dread getting fat, whether they are overweight or not.

Diets have to be planned carefully for boys as well as girls. Both have such great need for protein, the B vitamins and vitamin C—and in fact every nutrient—that they cannot afford to fill up on foods that contribute empty calories alone.

A teenage boy usually winds up with a better diet than a teenage girl because his need for calories is so great that if food is available he will eat it.

Some boys, however, may neglect foods containing important nutrients.

A teenage girl's need for calories is considerably less. She is more likely to get enough vitamin C because of her liking for salads and fruits, but her protein and iron intake may be low.

Both boys and girls tend to neglect foods containing calcium, vitamin A, riboflavin, and iron. During the growth spurt, ample supplies of all the nutrients are needed for muscle, bone and blood.

The overweight teenager may eat the same kinds of foods as his average friend, but too much of them. Rich desserts and many of the usual snack foods could be replaced with fresh fruits and vegetables. Also, he may be less active.

Instead of a crash diet to take off pounds in a hurry, an overweight teenager should develop the well-balanced eating habits he needs for the rest of his life.

The underweight adolescent may or may not be satisfied with his state and may need help in learning how to gain weight.

It should be noted that anemia may occur in both sexes at this age, although the monthly blood loss from menstruation puts girls in the more dangerous position.

Acne, the other blight on the teen years, is usually caused by hormone changes and not by diet.

LATE TEENS AND EARLY TWENTIES.

Growth ends somewhere during the later teens and early twenties when maturity is reached and the body's slowdown begins.

Compared with their youth, men and women need less protein and calcium—about two cups of milk a day provides enough calcium.

Men usually get enough iron without making a special effort. Women must be sure to get extra supplies in their diets.

The amount of vitamin D adults get in fortified milk is enough.

Allowances for vitamins A and C are about the same as they were in younger days. Adults can get enough vitamin A in dark green leafy vegetables or deep yellow ones when eaten three times a week.

They need to be eaten along with the recommended daily servings of such foods as whole milk, vitamin A fortified skim milk, cheese made from whole milk, and butter or vitamin A enriched margarine. One serving of citrus fruit or juice along with other fruits and vegetables is an easy way to get enough vitamin C.

Most adults use fewer calories than they did in their teens and weight control may be a problem.

Gross overweight usually means medical problems, so, generally, an adult should try to maintain for the rest of his life the weight considered normal for him at age 25. This means that the right amount of food at 30 may be too much at 40.

Calorie counting becomes necessary. A mere 20 extra calories a day could add two pounds of weight in a year.

What's two pounds? It's 80 extra pounds between the ages of 25 and 65!

Adults have some choice about which foods to limit. Such foods as pastries, cakes, salad dressings, gravies and nuts, if eaten frequently may supply too many calories for many people.

Frying may add fat no matter how well the food is drained.

Sugar, candies, syrup, jellies, soft drinks and alcohol add calories but few nutrients to the diet. Of course, cakes, dressings, jams and candy do make the diet more interesting, but when used, the extra calories should be compensated for by reducing portions of food. Foods such as meats, milk, fruits, vegetables and cereals or bread are necessary—the need for vitamins, minerals and protein continues even though calories are being reduced.

Be careful when you are counting calories. A diet that furnishes 1,500 calories a day could be lacking in some important nutrient, depending on the choices made.

The easiest way to bring the total nutrient value of a low-calorie diet up to standard is to be sure that each food does double duty.

For a mid-morning pickup, fresh fruit or juice can provide vitamin C and A with relatively fewer calories.

By the same token, a plate of fresh fruit, instead of apple pie for dessert, can provide vitamins C and A in addition to calories.

EATING IN LATER YEARS.

The process of aging begins the moment a person is conceived.

It is hard to say exactly when youth becomes middle age, or middle age becomes old age. Calendars tell only part of the story.

Some men and women in their eighties are still going strong; some are feeble in their sixties. The cells of an older person's body undergo changes and some of the cells are damaged. The body's organs don't function as well.

Vision is not as clear, hearing is not as sharp, and the digestive systems may act up.

The older person's condition is affected by all the accidents, infections and other hazards of living that he has experienced during his lifetime.

This is when the results of a poor diet through the years can be seen.

All the nutrients that have been supplied—or not supplied—are giving the cells more—or less—strength to fight the aging process and disease.

The food likes and dislikes developed over the years may become barriers to good nutrition. Older people need fewer calories.

Men and women 55 to 75 years old need 150 to 200 fewer calories per day than when they were 35 to 55, but their needs for essential nutrients are unchanged. It is more important than ever for each food to do double duty. There is not much room for low nutrient, high calorie food.

Old age like the teen years is a time of learning to live with changes. Often the changes are serious and tiring.

The strains of old age may be made worse by changes in living patterns. The eating habits of the elderly can be influenced by loss of teeth, retirement, reduced income, moving out of a familiar house or neighborhood, or the number of people with whom they live.

DIET FOR ADULTS

PURPOSE

To provide a nutritionally adequate diet for persons 19 to 65 years of age, offering a variety of foods for persons who require no dietary modification.

NUTRITIONAL ADEQUACY

This diet meets the Recommended Dietary Allowances when the types and amounts of foods suggested are included every day. The recommended amount of iron will not be met for certain age groups unless iron-rich foods are served frequently. At lower calorie levels, the Recommended Dietary Allowances for thiamin will not be met for certain age groups.

DIET PRINCIPLES

This diet should include at least the minimum number of servings from the basic food groups. Foods not specified, such as those in the "Other" and "Miscellaneous" categories, may be used in moderation to satisfy the need for additional calories.

FOOD GROUPS	RECOMMENDED	NOT RECOMMENDED
Meat & Meat Alternates	2 or more servings. One serving should be meat, fish or poultry. The other serving may be eggs, cheese, dried beans, dried peas, peanut butter or meat, fish, or poultry. Prepared any way.	
Milk & Milk Products	2 or more cups. May be whole, 2% skim or evaporated milk; or buttermilk. May be used as a beverage or in cooking. Also includes yogurt, cheese and cheese products. Nonfat dry milk may be used in cooking.	
Bread & Cereal	4 or more servings. All kinds. Whole grain or enriched. Also includes macaroni, noodles, spaghetti, rice.	
Fruits & Vegetables	4 or more servings total.	
Vitamin C Source	1 serving.	
Dark Green or Orange	1 serving.	
All Others	2 or more servings. Includes potatoes and all other fruits and vegetables.	
Fats & Oils	2 or more servings. All kinds.	
Other	Moderate amounts, not to exceed caloric requirement. Includes dessert items such as cake, cobbler, cookies, gelatin, pies, sherbet and snack items such as potato chips.	

FOOD GROUPS	RECOMMENDED	NOT RECOMMENDED
Beverages & Fluids	As desired. Carbonated beverages, coffee, coffee substitutes, decaffeinated coffee, fruitades, tea, broth.	
Miscellaneous	As desired. Condiments (all kinds), catsup, coconut, garlic, mint, mustard, olives, parsley, pickles, sauces (cream sauce, gravy, meat sauces), spices (all kinds), vinegar.	

SAMPLE MEAL PLAN

BREAKFAST

Citrus Fruit or Juice, 1/2 cup
Cereal, 3/4 cup
Toast, 2 slices
Margarine, 1 tsp.
Jelly, 1 tbsp.
Sugar, 1 tsp.
Jelly, 1 tbsp.
2% Milk, 1 cup
Beverage

LUNCH OR SUPPER

Soup or Juice, 1/2 cup
Meat or Meat alternate, 2 oz
Vegetable, 1/2 cup
Salad, 1/2 cup
Salad Dressing, 1 tbsp.
Bread, 1 slice
Margarine, 1 tsp
Fruit or Dessert, 1/2 cup
2% Milk, 1 cup

DINNER

Meat, Poultry or Fish, 3.oz
Potato or Substitute, 1/2 cup
Vegetable, 1/2 cup
Salad, 1/2 cup
Salad Dressing, 1 tbsp.
Bread, 1 slice
Margarine, 1 tsp
Fruit or Dessert, 1/2 cup
Sugar, 1 tsp.
Beverage

The diet as listed in the Sample Meal Plan contains approximately:

Protein	89 grams(20%)	Carbohydrate	230 grams(52%)
Fat	54 grams(28%)	Calories	1746

The plan can be adjusted to meet the caloric need variations of the individual.

To provide a more accurate determination of the nutritional adequacy, a sample meal plan for each diet except infants was analyzed by the Nutrichat Computer program developed by the University of Missouri College of Home Economics.

The regular diet that follows was the basis for the modified diets and is presented along with a portion of the computer analysis, as an example of how the analysis was performed.

SAMPLE REGULAR DIET

BREAKFAST

Orange Juice, 1/2 cup
Oatmeal, 3/4 cup
Whole Wheat Toast, 2 slices
Margarine, 2 tsp.
Jelly, 1 tbsp.
Sugar, 1 tsp.
2% Milk, 1 cup
Coffee, 1 cup

LUNCH OR SUPPER

Tomato Soup, 1/2 cup
Roast Turkey, 2 oz
Green Beans, 1/2 cup
Lettuce Salad, 3.5 oz
French Dressing, 1 tbsp.
White Bread, 1 slice
Margarine, 1 tsp.
Fruit Cocktail, 1/2 cup
2% Milk, 1 cup

DINNER

Pot Roast of Beef, 3 oz
Boiled Potatoes, 1/2 cup
Carrots, 1/2 cup
Coleslaw, 1/2 cup
Brown and Serve Roll, 1
Margarine, 1 tsp.
Angel Food Cake, 1 slice
Sugar, 1 tsp.
Coffee, 1 cup

NUTRIENT INTAKE ANALYSIS -- BY MEAL

Meal	Calories	Protein (g)	Vit. A (IU)	Vit. C (mg)	Calcium (mg)	Iron (mg)
Breakfast	567	18.4	1082	62	402	3.1
Lunch	559	33.5	2728	35	421	5.7
Dinner	621	37.8	11619	36	88	6.5
Snacks	0	0.0	0	0	0	0.0
24 Hour Total:	1747	89.7	15429	133	910	15.3

NUTRIENT	RDA	TOTAL CONSUMED (24-Hour)	% RDA
Calories	2700.0	1746.80	65 %
Protein, (g)	56.0	89.66	160 %
Total Fat, (g)		54.46	
Carbohydrate, (g)		230.28	
Fiber, (g)		4.78	
Vitamin A, IU	5000.0	15428.64	309 %
Vitamin C, (mg)	60.0	132.52	221 %
Vitamin D, (ug)	5.0	5.00	100 %
Thiamin, (mg)	1.4	1.12	80 %
Niacin, (mg) N.E.	18.0	25.66	143 %
Riboflavin, (mg)	1.6	1.63	102 %
Calcium, (mg)	800.0	910.33	114 %
Iron, (mg)	10.0	15.29	153 %
Magnesium, (mg)	350.0	207.00	59 %
Phosphorus, (mg)	800.0	1246.38	156 %
Potassium, (mg)		3256.77	
Sodium, (mg)		2651.40	

Caloric Contribution From Proteins, Fats & Carbohydrates		Suggested Intake For Balanced Diet
Proteins	20%	10% - 15%
Fats	28%	25% - 35%
Carbohydrates	52%	55% - 60%

Source: Missouri Diet Manual, 6th Edition, Missouri Department of Health and Missouri Department of Social Services - Division of Aging

DIET FOR OLDER ADULTS

PURPOSE

To provide a nutritionally adequate diet offering a variety of foods for persons 65 years and older.

NUTRITIONAL ADEQUACY

This diet meets the Recommended Dietary Allowances when the types and amounts of foods suggested are used daily.

DIETARY PRINCIPLES

The single best criterion to be used in planning diets for the older adult is attainment of nutritional requirements as currently defined by the Food and Nutrition Board of the National Research Council. The diet outlined for the younger adult (see "Diet for Adults") serves as the foundation for the diet after 65 years of age. The diet should be planned to include at least the minimum number of servings from the basic food groups.

Caloric requirements generally are lower for older adults. Once the minimum servings have been chosen, additional foods must be selected with care to prevent exceeding caloric needs. Foods from the "other" category and extra servings of fats and oils should be avoided if caloric needs have been met.

Vitamin and mineral supplementation is not needed as long as the individual consumes the variety of foods recommended. Supplements may be prescribed by a physician if medical examination reveals specific deficiencies or if a nutritional history reveals long-term poor eating habits.

SAMPLE MEAL PLAN

BREAKFAST

Citrus Fruit or Juice, 1/2 cup
Cereal, 1/2 cup
Egg, 1
Toast, 2 slices
Margarine, 2 tsp.
Jelly, 1 tbsp.
Sugar, 1 tsp.
2% Milk, 1 cup
Beverage

LUNCH OR SUPPER

Soup or Juice, 1/2 cup
Meat or Meat Substitute, 2-3 oz.
Vegetable, 1/2 cup
Bread, 2 slices
Margarine, 1 tsp.
Fruit, 1/2 cup
2% Milk, 1 cup
Beverage

DINNER

Meat or Meat Substitute, 2-3 oz
Potato or Potato Substitute, 1/2 cup
Vegetable, 1/2 cup
Salad, 1/2 cup
Bread, 1 slice
Margarine, 1 tsp.
Fruit or Dessert, 1/2 cup
Sugar, 1 tsp.
Beverage

BEDTIME

2% Milk, 1/2 cup or Fresh Fruit, 1 serving
and
sandwich, 1/2

The diet as listed in the Sample Meal Plan contains approximately:

Protein	93 grams (19%)	Carbohydrate	257 grams (52%)
Fat	63 grams (29%)	Calories	1826

The plan can be adjusted to meet the individual's caloric needs.

The following suggestions may enhance the enjoyment and intake of foods:

1. Nourishing bed time snacks are especially appropriate if there is a substantial time lapse between the evening meal and bed time.
2. Congregate meal settings should be encouraged.
3. Allow adequate time for the resident to eat a leisurely meal.
4. Small frequent meals or snacks may be better tolerated than three heavier meals.
5. Breakfast is often the best tolerated meal and the one for which the older adult has the best appetite.
6. Excess fat may delay digestion. If discomfort after meals occurs, avoid or decrease use of fatty meats and fish, fried foods, gravies, sauces, salad dressing: [illegible] rich desserts.
7. Many older adults tolerate a heavy meal better at noon than in the evening.
8. Avoid coffee and tea late in the day if insomnia is a problem.

Although the aging process may modify nutrient needs and/or utilization, chronological age is not the only determing factor in providing meals for the older adult. The person planning meals must consider the individual and his/her specific needs for texture and nutrient modification to provide optimun nutrition. A key factor, therefore, in planning meals for older adults is a sensitive consideration of the role of diet in the total health care plan.

Following are several factors identified which may influence the individual older adult's ability to maintain adequate nutrition. Not all of these problems will occur for every resident nor will they necessarily persist as permanent concerns once noted. Reassessment of any dietary modification should be made frequently and on a schedulted basis.

I. ORAL

A. *Dentition:* Many older persons require dentures which in some cases fit poorly or are not worn. This may interfere with the mechanics of eating, and modification in the texture of foods may be necessary. Tender or finely cut meats, casseroles and softer foods are generally preferred over ground meats or pureed foods. Consultation with the patient to determine the degree of modification is desirable.

B. *Other:* Decreased salivary secretions may lead to swallowing difficulties. In such cases, moist foods, gravies and sauces and adequate fluids should ease the problem. Older persons may also experience a declining sense of taste and/or smell which should be addressed if it limits intake.

II. GASTROINTESTINAL

A. *Impaired digestion and absorption:* Decreases in gastric secretions and secretions of certain enzymes may result in decreased digestion and absorption of a variety of nutrients. Some nutrients of particular concern are Vitamin B 12, calcium and dietary fats. If specific food intolerances are noted, those foods should be avoided making sure substitutions are made for the nutrients they contain.

B. *Decreased GI motility:* A decrease in the tonus of the gastrointestinal muscles often occurs due to illness and/or drug usage. This may lead to delayed GI transit time and may cause abdominal distress. Allow adequate time between meals to relieve discomfort.

C. *Constipation:* Increased GI transit time and/or adequate intakes of fluids and fiber may lead to constipation. The older adult may become anxious if he/she does not have a daily bowel movement. If concern over bowel movements is noted, the resident should be reassured about normal bowel habits. An increased intake of fluids and/or a high fiber diet may relieve simple consitpation. Six to eight glasses of fluid are recommended along with maintenance of adequate activity program (see Increased Fiber Diet).

D. *Other:* An excessive production of gas is fairly common for many older adults and may be due to swallowing air. Factors contributing to this problem include rapid eating or gulping of liquids, using a straw, chewing gum, sucking hard candies or other activities which cause the individual to swallow air. The cause of the problem should be identified and eliminated.

III. PERSONAL FACTORS

A. *Handicapping conditions:* The older adult may have impairment of hand or arms which may make eating difficult. A stroke victim may have impaired function only one side of his body. Adaptive utensils may be needed and the texture of food may need to be modified. Assistance with feeding may be needed, but the resident should be encouraged to be as independent as possible. An occupational therapist can be very helpful in developing an appropriate feeding plan.

B. *Altered emotional or mental status:* Many times the elderly person can become confused when in the hospital or nursing home. It is important to help him to understand the events occurring around him. Let him know when it is mealtime, what meal it is and what foods are being served. Depression is another common problem for the older adult. Assistance may be needed with menu selection and at meal time to ensure that the resident receives and eats foods chosen.

IV. WEIGHT CONTROL

A. *Underweight:* Loss of weight may be due to a number of factors, and some of them have already been discussed. Medical problems and illness may cause difficulty with adequate intake. The cause of any weight loss should be carefully identified and an appropriate care plan developed

B. *Obesity:* This is sometimes a problem for the older adult if longstanding eating habits providing excess calories are maintained and if activity levels are decreased. Since obesity is a risk factor for development of diabetes and cardiovascular disease, a care plan including a weight control program should be developed, instituted and carefully monitored.

V. MEDICAL PROBLEMS

A. *Nutrient-Drug interactions:* Many older adults take several different types of medications daily which can affect their nutritional status. The medications that residents take should be reviewed to ascertain possible drug-nutrient interactions.

One common problem is the use of potassium losing diuretics. In some cases, body potassium may become depleted to the extent of causing low serum potassium level. This can lead to muscle weakness and cardiac arrhythmia. The intake of potassium rich foods is recommended for persons on these potassium losing medications (see High Potassium Diet). In some cases, supplemental potassium will be prescribed by the physician.

B. *Decubitus Ulcers:* Decubitus ulcers are often seen in the institutionalized resident. Poor nutritional status can compound this problem. In addition to good nursing care required for treating this problem, it is essential that the resident receive adequate nutrients. An adequate intake of high quality protein, based on desirable body weight, sufficient calories for maintenance of desirable body weight, and an adequate vitamin and mineral intake are necessary to promote healing of the decubitus ulcer.

C. *Dehydration:* This condition may be seen in institutionalized patients and may be identified by a lethargic or semi-comatose condition. It is recommended that the older adult drink six to eight cups of water or other fluids per day to maintain adequate hydration. Many older adults may need reminders to maintain this fluid intake.

D. *Tube Feedings:* It may be necessary to feed some residents by tube to maintain an adequate nutrient and fluid intake. Commercial formulas are recommended (see Enteral Alimentation Section). Use of blenderized "house" diets is not recommended because of problems with preparation, administration, storage and sanitation. Any opened formula should be discarded after 24 hours due to possible bacterial contamination. This contamination can lead to severe illness. Diarrhea or discomfort may occur if the tube feeding ioduced and/or increased too quickly or administered at an improper temperature (see Tube Feeding Administration Protocols.).

READINGS:

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Source: *Missouri Diet Manual*, 6th Edition, Missouri Department of Health and Missouri Department of Social Services Division of Aging

LESSON PLAN: 27

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: V-27 OR DEMONSTRATION:

MEAL PLANNING, SHOPPING FOR FOOD, MEAL PREPARATION
(Lesson Title))

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List four food groups and give examples of food in each - See Lesson 26.

2. Discuss the nutritional needs of each age group - See Lesson 26.

3. Plan a meal using the dietary guidelines established using the Basic Four food groups. (See H.O. 5 - Lesson 26)

4. Prepare a shopping list using a planned menu.

5. List four guidelines used when buying food.

6. Shop for groceries using the financial resources available to the client.

7. Prepare a meal using recipes for planned menu.

8. Set table for client's prepared meal.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. H.O. 1 Food Exchange List - especially for diabetic clients
2. H.O. 2 We Want You To Know About Labels On Foods
3. H.O. 3 FDA Consumer
4. H.O. 4 Labeling for Special Dietary Use
5. H.O. 5 Food Facts I

6. H.O. 6 Unit Pricing, Good Buys, Storing Food
7. H.O. 7 Beef Chart
8. H.O. 8 Abbreviations, Equivalents, Equipment
9. H.O. 9 Key Ideas: Preparing a Meal, Cooking Methods
10. H.O. 10 WIC Program
11. H.O. 11 Substitutions
12. H.O. 12 Table Setting
13. Computer Program - *You Are What You Eat* - The Growing Seed Co.
14. Computer and Printer
15. Nutrition Labeling Worksheet

TEACHER RESOURCES:

INTRODUCTION:

As a N.A., your clients may need you to plan with them a menu based on established guidelines of the four food groups. You may have to purchase the food within a budget and prepare and serve the food as well. This lesson will prepare you to do this. Hope you buy it!

HOW TO READ NUTRITION LABELS

Nutrition information is per serving. The label gives the size of a serving (for example, one cup, two ounces, 1 tablespoon), how many servings are in the container; how many calories per serving; and the amounts in grams of protein, carbohydrate, and fat per serving.

Protein is listed twice, in grams and as a percentage of the U.S. Recommended Daily Allowance.

Seven vitamins and minerals must be shown, in a specific order. Listing of other vitamins, and of cholesterol, fatty acid, and sodium content is optional.

A KEY TO METRIC UNITS

Nutrition labels show amounts in grams rather than ounces, because grams are a smaller unit of measurement, and many food components are present in small amounts. Here is a guide to help you read nutrition labels:

1 pound = 454 grams (g)
1 ounce = 28 grams (g)
1 gram = 1,000 milligrams (mg)
1 milligram = 1,000 micrograms (mcg)

WHAT U.S. RDA MEANS

U.S. Recommended Daily Allowances (U.S. RDA's) are the amounts of protein, vitamins, and minerals that an adult should eat every day to keep healthy. Nutrition labels list the U.S. RDA by percentage. For example, the label may show that one serving of the food contains 35 percent of the Recommended Daily Allowance of vitamin A and 25 percent of the Recommended Daily Allowance of iron. The total amount of food an individual eats in a day should supply about 100 percent of the Recommended Daily Allowance of all essential nutrients.

NUTRITIONAL QUALITY

When foods are frozen and packaged into "frozen dinners," do they give you the same protein, vitamins, minerals, and other nutrients you would find in these same foods when they are fresh? Labels can help you determine whether you really are getting the nutrient value you should. FDA is setting nutritional quality guidelines for certain classes of foods. A product that complies with the guidelines may include on the label the statement that it "provides nutrients in amounts appropriate for this class of food as determined by the U.S. Government."

GETTING MORE FOR YOUR MONEY

There may be a difference in quality among different brands of the same food, but often price is the main difference. When you're shopping, compare "net contents" and "price" on products, and see which product or size offers you the best value.

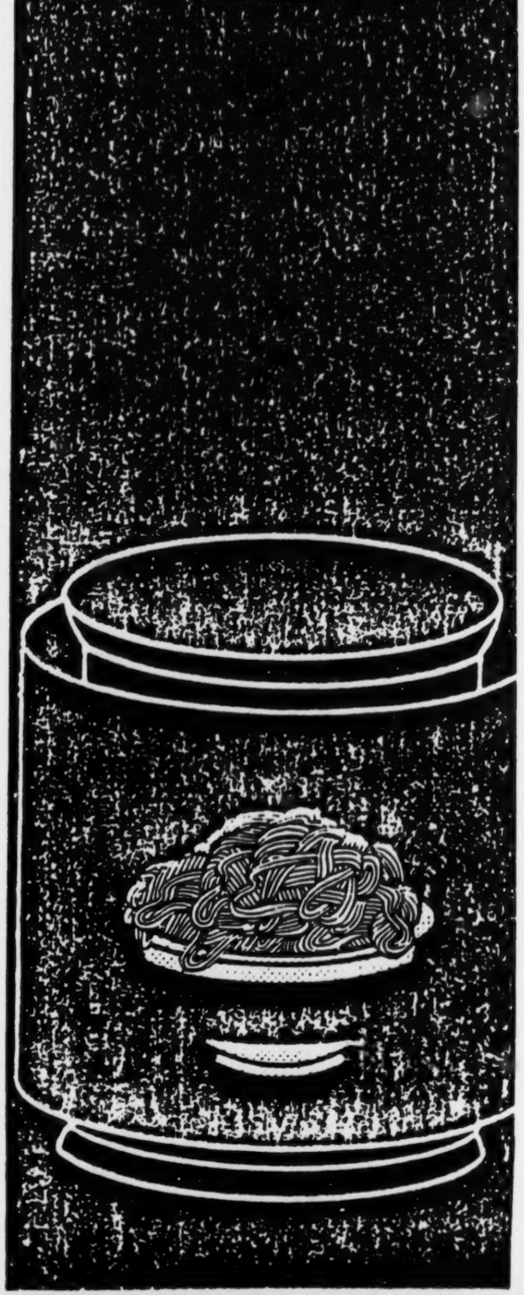
Some stores have unit pricing. This means the store tells you, on cards placed near the food, how much the product costs per ounce or pound or other unit of measurement. This give you a way to compare brands and costs.

FOOD LABELS AND YOU

Food labels provide you with information you need to be an alert consumer. Labels can help you understand what you are buying and how to use it. They can help you protect your money and your health. Make it a habit to read all labels carefully.

U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
Public Health Service
Food and Drug Administration
Office of Public Affairs
Rockville, Maryland 20857
HEW Publication No. (FDA) 77-2076

We Want You To Know About
Labels On Foods



WE WANT YOU TO KNOW ABOUT LABELS ON FOOD

HO 2

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FDA Consumer
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HEW Publication No. (FDA) 77-2083

U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
Public Health Service
Food and Drug Administration
Office of Public Affairs

FDA CONSUMER HO 3

GRADES

Some food products carry a grade on the label, such as "U.S. Grade A." Grades are set by the U.S. Department of Agriculture, based on the quality levels inherent in a product—its taste, texture, and appearance. U.S. Department of Agriculture grades are not based on nutritional content.

Milk and milk products in most States carry a "Grade A" label. This grade is based on FDA recommended sanitary standards for the production and processing of milk and milk products, which are regulated by the States. The grade is not based on nutritional values. However, FDA has established standards for milk which require certain levels of vitamins A and D when these vitamins are added to milk.

OPEN DATING

To help consumers obtain food that is fresh and wholesome, many manufacturers date their product. Open dating, as this practice often is called, is not regulated by FDA, but the following information may be helpful to you.

Four kinds of open dating are commonly used. To benefit from open dating, the consumer needs to know what kind of dating is used on the individual product and what it means.

Pack Date—This is the day the food was manufactured or processed or packaged. In other words, it tells how old the food is when you buy it. The importance of this information to consumers depends on how quickly the particular food normally spoils. Most canned and packaged foods have a long shelf life when stored under dry, cool conditions.

Pull or Sell Date—This is the last date the product should be sold, assuming it has been stored and handled properly. The pull date allows for some storage time in the home refrigerator. Cold cuts, ice cream, milk, and refrigerated fresh dough products are examples of foods with pull dates.

Expiration Date—This is the last date the food should be eaten or used. Baby formula and yeast are examples of products that may carry expiration dates.

Freshness Date—This is similar to the expiration date but may allow for normal home storage. Some bakery products that have a freshness date are sold at a reduced price for a short time after the expiration date.

CODE DATING

Many companies use code dating on products that have a long "shelf life". This is usually for the company's information, rather than for the consumer's benefit. The code gives the manufacturer and the store precise information about where and when the product was packaged, so if a recall should be required for any reason the product can be identified quickly and withdrawn from the market.

UNIVERSAL PRODUCT CODE

Many food labels now include a small block of parallel lines of various widths, with accompanying numbers. This is the Universal Product Code (UPC). The code on a label is unique to that product. Some stores are equipped with computerized checkout equipment that can read the code and automatically ring up the sale. In addition to making it possible for stores to automate part of their checkout work, the UPC, when used in conjunction with a computer, also can function as an automated inventory system. The computer can tell management how much of a specific item is on hand, how fast it is being sold, and when and how much to order.

SYMBOLS ON FOOD LABELS

The symbol "R" on a label signifies that the trademark used on the label is registered with the U.S. Patent Office.

The symbol "C" indicates that the literary and artistic content of the label is protected against infringement under the copyright laws of the United States. Copies of such labels have been filed with the Copyright Office of the Library of Congress.

The symbol which consists of the letter "U" inside the letter "O" is one whose use is authorized by the Union of Orthodox Jewish Congregations of America, more familiarly known as the Orthodox Union, for use of foods which comply with Jewish dietary laws. Detailed information regarding the significance and use of this symbol may be obtained from the headquarters of that organization at 116 E. 27th St., New York, New York 10016.

The symbol which consists of the letter "K" inside the letter "O" is used to indicate that the food is "Kosher," that is, it complies with the Jewish dietary laws, and its processing has been under the direction of a rabbi.

None of the symbols referred to above are required by, or are under the authority of, any of the Acts enforced by the Food and Drug Administration.

Margaret Morrison is a staff writer with FDA's Office of Public Affairs.

LESSON PLAN: 27

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

OUTLINES: (Key Points)

I. The Four Food Groups

  A. Review from Lesson 26

II. Dietary Guidelines - See Lesson 26 - VI A

  A. Infants, children
  B. Teenagers
  C. Adults
  D. Elderly

III. Meal Planning and Shopping for Food (Teach from Handouts)

  A. Determine menu - See Lesson 26 (CD-1)

  B. Prepare shopping list from menu, client's needs, likes and dislikes, check staples (H.O. 1)

    1. Brands preferred

    2. Work within the client's food budget (CD-2)
      a. Use manufacturer's coupons
      b. Use Food Stamps (CD-7)
      c. Use W.I.C. (Women, Infant, Children) vouchers (H.O. 10)
      d. Client's money
      e. Other

  C. The Grocery Store - Guidelines

    1. Use prepared list

    2. Unit pricing (H.O. 5 & 6) (CD-4)

    3. Open date coding (H.O. 3) (CD--5)

    4. Read labels to choose the best product for client (CD-3) (H.O. 2, 4, 5)
      a. Food (ie: special diet - sodium restricted)
      b. Non-food items
    5. Compare prices and brands (H.O. 5 & 6)
    6. Choose produce, dairy, meat products (CD-6) & (H.O. 6 & 7)
    7. Store food at home (H.O. 6)
      a. Perishable
      b. Non-perishable
    8. Save receipts (CD-8)

III. Meal Preparation

A. Select recipes that are simple and easily prepared

B. Basic food preparation equipment (H.O. 8) (CD-9)

C. Basic measuring (H.O. 8)

D. Common recipe abbreviations (H.O. 8)

E. Common cooking terms (H.O. 9)

F. Some substitutions (H.O. 11)

IV. Meal Service

A. Prepare client for meal at table

B. Set table for easy and comfortable use by client (H.O. 12)

V. Summary and Conclusion

A. Review Four Food Groups

B. Dietary Guidelines

C. Shopping

D. Meal Preparation

E. Meal Service

After reviewing food groups, nutritional needs of all ages and dietary guidelines, you have learned how to shop for food after planning a menu for your client. The H.H.C.A. nurse assistant will do this. Preparing the meal has been discussed and you have learned much about items in the kitchen. Always ask questions of your supervisor if in doubt about anything involving food for your client. Remember, meal time is the most important time of the day for each client.

LESSON PLAN: 27

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. How do you plan a menu?
2. What are some financial resources that may be available to a client?
3. Name information that may appear on a food label.
4. How would you use unit pricing when buying ground beef?
5. Why is open dating used on dairy products?
6. What features would you look for when choosing produce for a client?
7. Name several items not allowed for purchase when using Food Stamps.
8. Why is it important to save all shopping receipts?
9. Why is it important to read and follow recipes?

CLASSROOM, LABORATORY, OR OTHER ACTIVITY:

1. Show films.
2. Interview class members for their food preferences.
3. Shop for selected food items from prepared menus.
4. Develop sample menus for a client.
5. Prepare selected foods from a menu.
6. Using empty food packages, compare various brands of a generic product.
7. Practice putting groceries away.
8. Practice setting table and set client up for meal service.
9. Using income guides:
    1. Plan a week's meals based on Basic 4 and good nutrition
    2. Plan shopping list
    3. Visit grocery store to price check all items

LESSON PLAN: 27

COURSE TITLE: NURSE ASSISTANT

UNIT V: FOOD AND NUTRITION

EVALUATION ITEMS:

Match each term to the correct definition.

_____	1.	bake	a.	An important guideline to use when purchasing food and non-food items.
_____	2.	boil	b.	Vitamins, minerals, calories, etc. are some items this label portion will give to you.
_____	3.	Food Stamps	c.	Tells the customer what the cost is by a particular quantity.
_____	4.	nutrition information	d.	To allow water to reach a temperature of 212o F.
_____	5.	open date coding	e.	Tells the customer how long an item will remain fresh.
_____	6.	quality	f.	A federal program allowing low-income people to further stretch their food dollar.
_____	7.	unit pricing	g.	To cook food in an oven.
_____	8.	W.I.C.	h.	This program allows the choice of healthier foods to pregnant/nursing mothers, their infants and children.

LESSON PLAN: 27

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

ANSWERS TO EVALUATION ITEMS:

1. g
2. d
3. f
4. b
5. e
6. a
7. c
8. h

How closely do you read the labels on the foods you buy? What do you look for: brand, price? Many people stop there, or even sooner. But the Food and Drug Administration thinks you should read a great deal more.

Labels help you get what you're shopping for, tell you how to use it, and in some cases can save you money.

BASIC INFORMATION

Not all food labels are alike. But certain information must be on all food labels:

- Name of product.
- Net contents or net weight. The net weight on canned food includes the liquid in which the product is packed, such as water in canned vegetables and syrup in canned fruit.
- Name and place of business of the manufacturer, packer, or distributor.

LIST OF INGREDIENTS

On most foods, the ingredients must be listed on the label. The major ingredient, by weight, must be listed first, followed in descending order by the other ingredients. Any additives used in the product must be listed, but colors and flavors do not have to be listed by name. The list of ingredients may simply say "artificial color" or "flavor." If the flavors are artificial, this must be stated. Butter, cheese, and ice cream, however, are not required to state the presence of artificial color.

FDA has set "standards of identity" for some foods. These standards require that all foods called by that name (such as catsup or mayonnaise) contain certain mandatory ingredients. Under the law, the mandatory ingredients in standardized foods need not be listed on the label. Manufacturers of standardized foods may add optional ingredients, however, and FDA is developing regulations requiring that optional ingredients in standardized foods be listed on the label.

WHEN YOU SEE "IMITATION"

Some foods are labeled as "imitations" of other foods. Under an FDA regulation, the word "imitation" is to be used on the the label when the product is not as nutritious as the product which it resembles and for which it is a substitute. If a product is similar to an existing one, and is as nutritious, then a new name will be made up for it. For example, when a product similar to cream was marketed years ago, it was not called "imitation cream." Instead, several new names were used, among them "coffee lightener."

GRADE

Some food products carry a grade on the label, such as "U.S. Grade A." Grades are set by the U.S. Department of Agriculture, based on the quality levels inherent in a product—its taste, texture, and appearance.

Milk and milk products in most States carry a "Grade A" label. This grade is based on FDA recommended sanitary standards for the production and processing of milk and milk products, which are regulated by the States. The grade is not based on nutritional value.

NUTRITION INFORMATION

Nutrition information is carried on the labels of many foods. Nutrition labels tell you how many calories are in a serving and also how much protein, fat, carbohydrate, and the percentage of U.S. Recommended Daily Allowances (U.S. RDA's) of protein and seven important vitamins and minerals. Nutrition information can help you plan better meals for you and your family, and also help you get better value for your money.

The labels at the right are examples of nutrition labels.

NUTRITION INFORMATION
(PER SERVING)
SERVING SIZE = 1 OZ.
SERVINGS PER CONTAINER = 12

CALORIES	110
PROTEIN	2 GRAMS
CARBOHYDRATE	24 GRAMS
FAT	0 GRAM

PERCENTAGE OF U.S. RECOMMENDED DAILY ALLOWANCES (U.S. RDA's)*

PROTEIN	2
THIAMINE	8
NIACIN	2

*Contains less than 2 percent of U.S. RDA for vitamin A, vitamin C, Riboflavin, Calcium, and Iron.

This is the minimum information that must appear on a nutrition label.

NUTRITION INFORMATION
(PER SERVING)
SERVING SIZE = 1 CUP
SERVINGS PER CONTAINER = 1

CALORIES	560	FAT (PERCENT OF CALORIES 53%)	33 G
PROTEIN	23 G	POLYUNSATURATED	2 G
CARBOHYDRATE	43 G	SATURATED	9 G
		CHOLESTEROL* (20 MG/100 G)	40 MG
		SODIUM (365 MG/100 G)	830 MG

PERCENTAGE OF U.S. RECOMMENDED DAILY ALLOWANCES (U.S. RDA's)

PROTEIN	35	RIBOFLAVIN	15
VITAMIN A	35	NIACIN	25
VITAMIN C (ASCORBIC ACID)	10	CALCIUM	2
THIAMINE (VITAMIN B₁)	15	IRON	25

*Information on fat and cholesterol content is provided for individuals who, on the advice of a physician, are modifying their total dietary intake of fat and cholesterol.

A label may include optional listings for cholesterol, fatty acids, and sodium.

reduction in the fetal mortality rate, a decrease in the incidence of low birth weight; increases in the percent of women receiving prenatal care; decreased numbers of preterm deliveries; increased head circumference of babies (greater brain growth); and enhanced quality of the diet. In general, the effects were greater among pregnant women who were at greater need (women with less education, or ethnic minority women).

WIC has also been shown to be cost effective. By decreasing the number of low birth weight babies born and the need for hospital care for these infants, medical costs are reduced. According to a Harvard University study, for every $1 spent on the prenatal component of WIC, up to $3 were saved in hospital costs of low birth weight babies. A recent study in Missouri found that for every $1 spent on the prenatal component of WIC, the state saved 83 cents in Medicaid costs in just the first 30 days after birth.

Participation Levels

In fiscal year 1986 (October 1, 1985 to September 30, 1986), about 40 percent of those eligible for the program actually participated. (This is based on USDA calculations of the estimated number of persons eligible for WIC as compared to the number participating).

Fiscal Year	Average Monthly Participation
1977	848,361
1981	2,117,843
1986	3,311,670

Funding

In fiscal year 1987, $1.66 billion was appropriated for the WIC program. The program is funded by the federal government, but also receives additional funding and in-kind services from some states. In fiscal year 1986, 9 states and the District of Columbia supplemented federal dollars for the WIC program with state appropriations.

WIC is not an entitlement program. Instead, there is a "cap" or limit on the amount of federal money allocated, which limits the numbers of participants who can be served.

In fiscal year 1987, the program funds supported an average monthly participation of 3.4 million participants at a cost of about $41 per person per month. Twenty percent of the total available funds are allocated among the states for the costs of nutrition services and administration associated with the WIC program; the remaining 80 percent of the funds go to purchase the foods.

Barriers to Participation

- Since WIC is not an entitlement program, the limit on federal dollars for the program keeps many eligible women, infants and children from receiving benefits. Waiting lists have had to be set up because many clinics have reached their maximum caseload and do not have the resources to serve more participants.
- Infant formula costs have increased at a much faster rate than other foods provided by WIC, and have caused higher total food package costs. This limits the number of people that can be served at the current funding level.
- Sometimes a site's distant location or limited hours of operation keep needy people from participating.

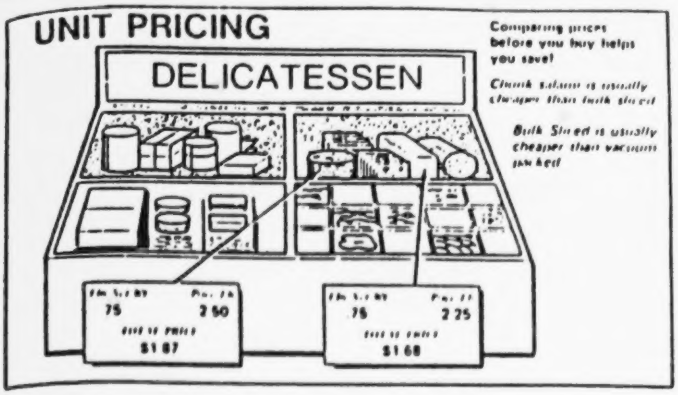
Options to Expand Participation

The WIC Program has continually proven itself as cost-effective and beneficial for its low-income participants. Expansion of the program through some or all of the following strategies would benefit even more at-risk low-income women, infants and children.

- Increase funding at the federal level.
- Increase funding at the state level.
- Make WIC an entitlement program so that funds will be provided to serve all who apply.
- Encourage states to adopt a program to reduce the costs of the WIC food package through creative food purchasing plans, such as obtaining rebates form infant formula companies.
- Make sites more accessible and easier to use for the low-income women and working families who are in need of the WIC Program.
- Increase outreach efforts.

UNIT PRICING

HO 6



Comparing prices before you buy helps you save!

Chunk salami is usually cheaper than bulk sliced

Bulk Sliced is usually cheaper than vacuum packed

Good Buys

Foods in season are almost always a good buy. Menus should be planned with seasonal foods in mind. The cost will be less and the selection greater.

In selecting foods, the best quality is not always necessary. In choosing tomatoes for a salad, the most attractive and usually the most costly would be desirable. However, in selecting tomatoes for tomato sauce, a less expensive product with perhaps a blemish on the skin might be considered a better buy.

When buying foods high in protein, you can reduce the cost by:

- Using poultry when it is cheaper than meat
- Considering cuts of meat that may cost more per pound but give more servings per person
- Learning to prepare less tender cuts of meat in casseroles or pot roasts
- Serving egg dishes such as omelettes
- Substituting dried bean and pea dishes for higher-cost meats
- Using fillers such as bread crumbs or pasta to make a meat dish serve more

STORING FOOD

After shopping for food economically, it is essential to store it properly. Proper storage prevents the loss of nutrients and possible food poisoning.

General Storage Hints

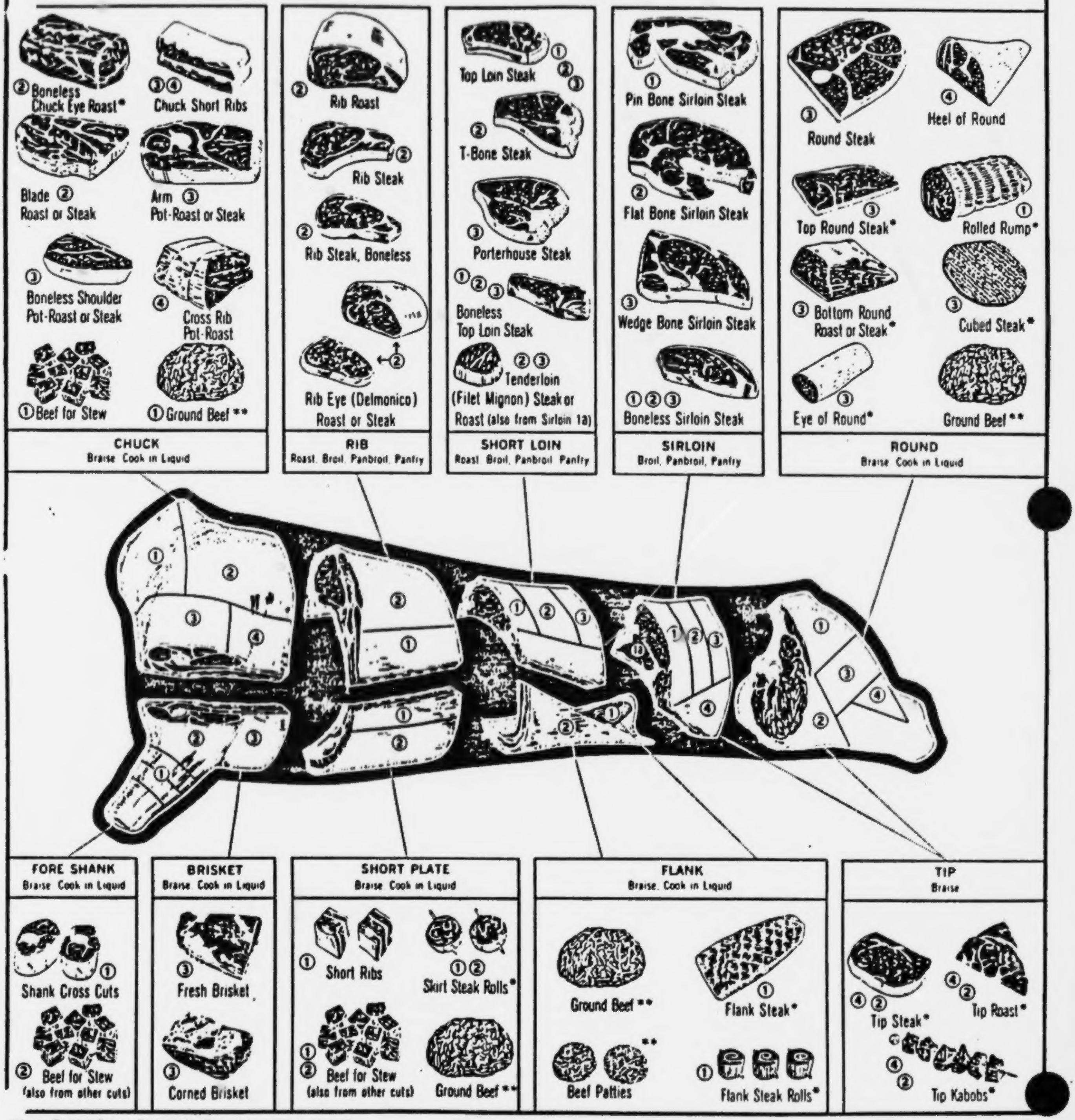
- Do not buy more food than you can safely store.
- Keep refrigerators operating properly by defrosting when needed.
- Check the expiration date on food before purchasing it. Choose the food with the longest time before expiration.
- Rotate food at home using the most recently purchased food last.
- Dry ingredients such as flour, sugar, cereal, and pasta products should be stored in tightly covered containers.

Tips for Specific Foods

- ***Meats.*** Refrigerate all meats. Ground meat and variety meats spoil more quickly than others, so use them soon after purchase.
- ***Fruits and Vegetables.*** Keep most fresh fruits and vegetables in the refrigerator in plastic bags, tightly covered containers, or the crisper.
- ***Bread.*** If wrapped properly, bread can be frozen to keep it most efficiently for a long time.
- ***Milk.*** Instant nonfat dry milk can be used in many of the same ways as whole milk and can be stored for much longer periods without refrigeration.
- ***Canned foods.*** Store in a cool, dry place.
- ***Frozen foods.*** Keep in freezer at 0°F temperature.

BEEF CHART

RETAIL CUTS OF BEEF — WHERE THEY COME FROM AND HOW TO COOK THEM


② Boneless Chuck Eye Roast*
③④ Chuck Short Ribs
Blade ② Roast or Steak
Arm ③ Pot-Roast or Steak
③ Boneless Shoulder Pot-Roast or Steak
④ Cross Rib Pot-Roast
① Beef for Stew
① Ground Beef **
CHUCK
Braise, Cook in Liquid
② Rib Roast
② Rib Steak
② Rib Steak, Boneless
② Rib Eye (Delmonico) Roast or Steak
RIB
Roast, Broil, Panbroil, Panfry
Top Loin Steak ①②③
② T-Bone Steak
③ Porterhouse Steak
①②③ Boneless Top Loin Steak
②③ Tenderloin (Filet Mignon) Steak or Roast (also from Sirloin 1a)
SHORT LOIN
Roast, Broil, Panbroil, Panfry
① Pin Bone Sirloin Steak
② Flat Bone Sirloin Steak
③ Wedge Bone Sirloin Steak
①②③ Boneless Sirloin Steak
SIRLOIN
Broil, Panbroil, Panfry
③ Round Steak
④ Heel of Round
③ Top Round Steak*
① Rolled Rump*
③ Bottom Round Roast or Steak*
③ Cubed Steak*
③ Eye of Round*
Ground Beef **
ROUND
Braise, Cook in Liquid
FORE SHANK
Braise, Cook in Liquid
① Shank Cross Cuts
② Beef for Stew (also from other cuts)
BRISKET
Braise, Cook in Liquid
③ Fresh Brisket
③ Corned Brisket
SHORT PLATE
Braise, Cook in Liquid
① Short Ribs
①② Skirt Steak Rolls*
①② Beef for Stew (also from other cuts)
Ground Beef **
FLANK
Braise, Cook in Liquid
Ground Beef **
① Flank Steak*
Beef Patties **
① Flank Steak Rolls*
TIP
Braise
④② Tip Steak*
④② Tip Roast*
④② Tip Kabobs*

*May be Roasted, Broiled, Panbroiled or Panfried from high quality beef

**May be Roasted (Baked), Broiled, Panbroiled or Panfried

This chart approved by

National Live Stock and Meat Board

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ABBREVIATIONS & EQUIVALENTS

To save space, measuring terms in recipes are often abbreviated:

Tablespoon—T. or Tbsp.
teaspoon—t. or tsp.
cup—C. or c.
pint—pt.
quart—qt.
ounce—oz.
pound—lb.

dozen—doz.
square—sq.
inch—in.
hour—hr.
minute—min.

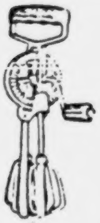
In metrics, symbols are used instead of abbreviations. Note they are not followed by a period.

meter—m
liter—L
gram—g
Celsius—C
joule—j

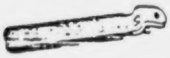
kilo—k
milli—m
centi—c
Example:
millimeter—mm

1 cup = 16 tablespoons
240 milliliters
8 fluid ounces
1 tablespoon = 3 teaspoons
15 milliliters
½ fluid ounce
1 teaspoon = ⅓ tablespoon
5 milliliters
⅙ fluid ounce
2 cups = 1 pint
480 milliliters
16 fluid ounces
4 cups = 1 quart
0.946 liter
32 fluid ounces
1 pound = 16 ounces
454 grams

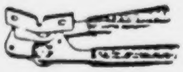
When you cook, you need certain kinds of equipment or tools to help you work easily and successfully. Learning to use each tool properly is a big step in mastering the art of cooking. Following is a list of some of the basic kitchen tools and what they do.



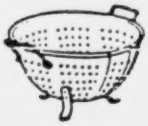
Beater, hand. Light beating such as scrambled eggs or pancake batter.



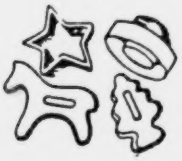
Bottle opener. Opens bottles.



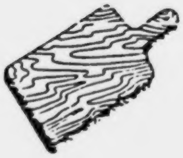
Can opener. Opens cans.



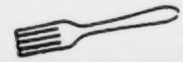
Colander. Drains liquid from food such as cooked spaghetti.



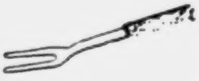
Cookie cutters. Cut cookies, biscuits from rolled dough; come in many shapes and sizes.



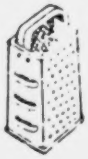
Cutting board. Protects counter top or table while cutting; made of wood or hard plastic.



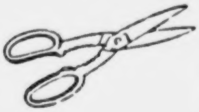
Fork, kitchen. Lifts or turns small food.



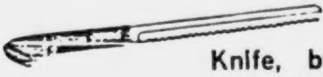
Fork, 2-tined. Lifts or turns heavy food.



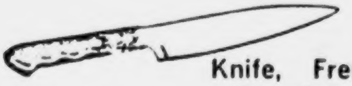
Grater. Grates food into tiny pieces.



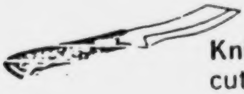
Kitchen shears. Cut food such as dried fruit, trim pie crust.



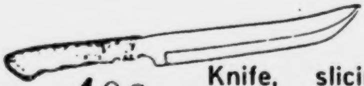
Knife, bread. Serrated edge for cutting bread.



Knife, French. Slices, cuts, minces, dices.



Knife, paring. Pares and cuts fruits and vegetables.

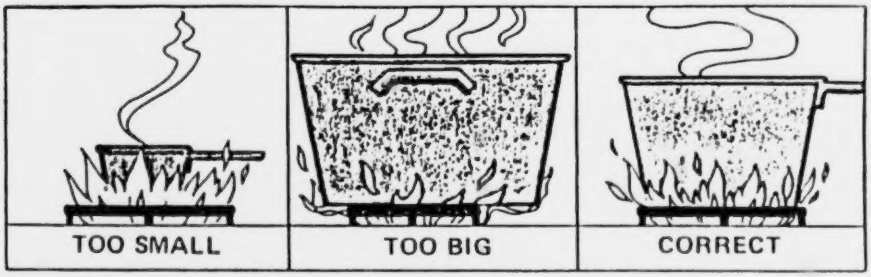


Knife, slicing. Slices meat, poultry.

Key Ideas: Preparing a Meal

When preparing foods, be aware of the amount of energy you are using. By doing this you will save time, money, and indicate your concern for the client's resources.

- Use the oven to prepare more than one food at a time.
- Do not preheat the oven longer than necessary.
- Put the pot on the correct-size burner. The burner should be as close to the size of the pan as possible. Too big a burner wastes fuel.



- Cover pots when they are cooking.
- Make one-dish meals.
- Make enough food for more than one meal and reheat the remaining servings.
- If you are using an electric range, turn off the heat a few minutes before the food is ready.
- Use the correct appliance for the job. Use small toaster ovens for small jobs and the big oven for big jobs.

Methods of Cooking

Bake or roast: to cook with dry heat in a confined space, such as an oven.

Boil: to cook in a liquid that is hot enough for bubbles to break on the surface.

Braise: a long, slow cooking method that makes use of moist heat in a tightly covered vessel at a temperature just *below* boiling. The cooking liquid should just barely cover the food to be braised. Braising is a good way to cook tough meats and vegetables, as the long cooking breaks down their fibers.

Broil: to cook directly under or above a source of heat.

Fry: to cook food in fat or oil. When only a small amount of fat is used, the process is called *pan frying* or *sautéing*. When larger amounts of fat are used—enough to cover the food—the process is called *deep frying* or *deep fat frying*.

Poach: a method of cooking used to preserve the delicate texture and prevent the toughening of foods. The food is covered by water or some other liquid. Depending on the type of food being cooked, the liquid may be either at the boil or at the boiling point.

Steam: a method of cooking in which the food is exposed to the steam of boiling water. The food must be *above* the liquid, never *in* it. The container is kept closed during cooking to let the steam accumulate. Steaming keeps a high proportion of the original flavor and texture of the foods because the nutrients are not dissolved in the cooking liquid as is the case with boiling or poaching. Steaming is a more time-consuming way of cooking, however.

Stew: a process of long, slow cooking of food in liquid in a covered pot with seasoning. Good for tougher cuts of meat.

Discover . . .

- **how to cook food in liquid.**
- **how to cook food in moist heat and dry heat.**
- **how to fry food.**
- **the secrets of protein cooking.**

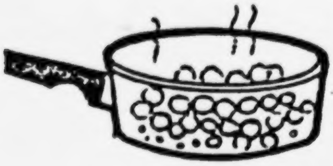
Food is cooked by one of four basic methods . . .

- In liquid
- In moist heat
- In dry heat
- In fat

Cook in Liquid

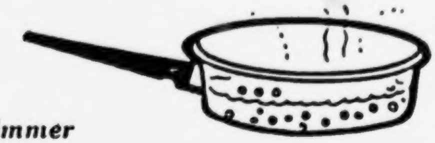
To *cook in liquid* means the food is covered with liquid. Food may be boiled, simmered, poached, or stewed.

Boil



Bring the liquid to the boiling temperature, 100 °C [212° F.]. When liquid boils, bubbles rise up continuously. They break the surface of the liquid. No matter how fast the liquid boils, the temperature cannot go above the boiling point. Rapid boiling does not cook food any faster than a slow boil. Use to . . .

- Bring cooking water for vegetables to the correct temperature.
- "Cook down" liquids such as sauces. This makes part of the liquid evaporate and gives the remaining liquid a stronger flavor.

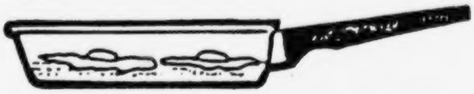


Simmer

Bring the liquid to a boil. Lower the heat so the bubbles rise slowly but do not break the surface. Use to . . .

- Cook foods slowly until they are done, such as vegetables, stews, soups, sauces, and gravies.

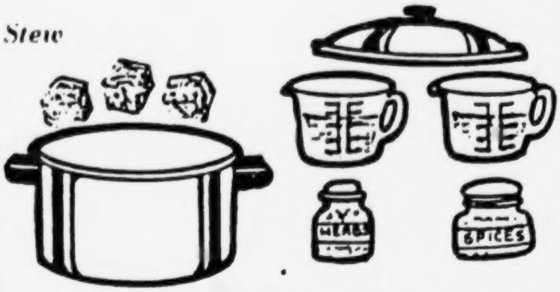
Poach



Food must cook slowly so it keeps its shape. Fast boiling breaks up the food. Bring the liquid to a simmer. Put the food in carefully. Cook at a simmer until done. Use to . . .

- Cook tender foods such as fish, eggs, and fruit.

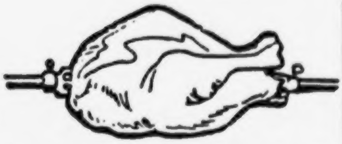
Stew



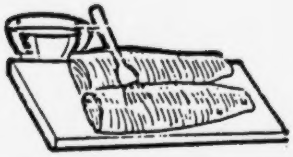
Cut food into small pieces. Cover food with liquid. Add seasonings. Cover and bring to a boil. Lower heat. Simmer until done. Use to . . .

- Cook fish, fruit, and less-tender cuts of meat and poultry.

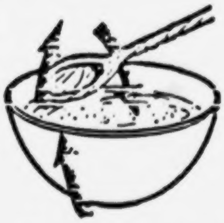
Become familiar with these terms. They can help you to use recipes more easily and successfully.



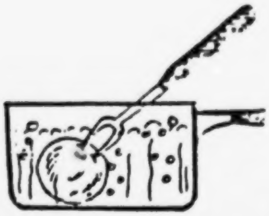
Barbecue. To roast or broil slowly on a pan or on a revolving spit over hot coals. Food is basted frequently with a hot, spicy sauce.



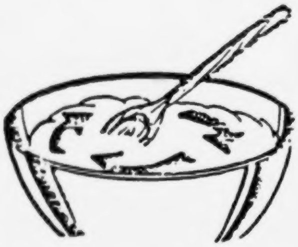
Baste. To brush or pour liquid over food as it cooks. This adds moisture to the food and keeps it from drying out. Melted fat, sauces, or meat drippings may be used.



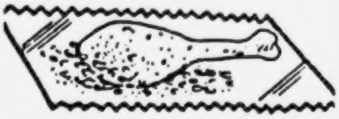
Beat. To mix ingredients thoroughly with a spoon or beater. To mix with a spoon, an over-and-over motion is used, beating hard and quickly.



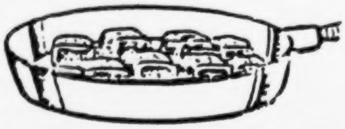
Blanch. To put food such as a fresh tomato in and out of boiling water very quickly. This makes it easier to peel. Also, to slightly precook vegetables before freezing.



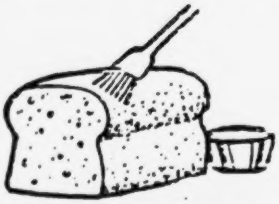
Blend. To mix two or more ingredients together well.



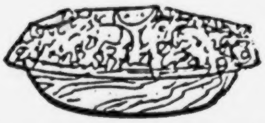
Bread. To coat a food such as chicken with fine crumbs such as bread or cereal.



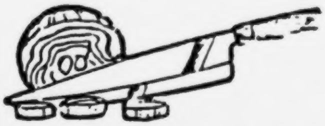
Brown. To cook food in a little hot fat or in the oven or broiler until the surface turns brown.



Brush. To use a brush or spoon to spread a liquid over food, such as beaten egg white or melted fat.



Chill. To refrigerate food until it is cold.



Chop. To cut food into small pieces with a knife, food chopper, or scissors.

October 1987

The Special Supplemental Food Program for Women, Infants, and Children (WIC)

Program Description

WIC is designed as a preventive nutrition program to provide supplemental nutritious foods, nutrition education and access to health care to low-income women, infants and children at nutritional risk. Congress created a WIC pilot project in 1972 (Public Law 92-433) and authorized WIC as a national program as part of the National School Lunch and Child Nutrition Act Amendments of 1975 (Public Law 94-105). WIC is currently authorized through September 30, 1989.

The program is administered and regulated by the U.S. Department of Agriculture (USDA) which grants funds to State Health Departments and Native American tribal agencies. State Health Departments fund local sponsors such as health agencies, social service agencies or other non-profit agencies that are capable of providing nutrition services. There are 87 state agencies and 1,672 local agencies currently participating.

The Congressional Committees with jurisdiction over the WIC Program are the House Education and Labor Committee and its Subcommittee on Elementary, Secondary and Vocational Education, and the Senate Committee on Agriculture, Nutrition, and Forestry, and its Subcommittee on Nutrition and Investigations.

Eligibility

Eligibility for WIC is three-fold.

1. One must be a pregnant, postpartum, or breast-feeding woman, an infant, or a child under the age of five.
2. One's household income must be below a level set by the State Agency (between 100 and 185 percent of the poverty level).
3. One must be certified to be at nutritional risk, which involves problems such as abnormal weight gain during pregnancy; a history of high-risk pregnancies such as a previous still birth or low birth weight baby; growth problems such as stunting, underweight, or obesity; iron-deficiency anemia; or inadequate dietary pattern.

Clients must apply for the program at the nearest WIC clinic, usually part of the county health department. Every six months or so, participants must be re-evaluated (recertified) to determine if they are still eligible for the program; this includes checking both nutritional risk and income eligibility, and age.

Benefits

WIC provides a monthly package of nutritious foods tailored to the dietary needs of infants, children, and pregnant, postpartum and breastfeeding women. The foods were specifically chosen to provide protein, iron, calcium, and vitamins A and C. These are the nutrients found most likely to be missing from the diets of low-income women and children. Authorized WIC foods are iron-fortified infant formula, infant cereal, milk, eggs, cheese, iron-fortified breakfast cereal, vitamin C-rich juice, beans and peanut butter. WIC foods are provided in one of three ways:

- "vouchers"–clients receive checks or coupons for specific foods which they then purchase in retail stores; or
- home delivery system–the foods are delivered to the participant's home; or
- direct distribution systems–where participants pick up food from a distribution outlet.

Offering nutrition education to the WIC participant is a program requirement. Within the certification period, they should receive two nutrition education contacts. These sessions are intended to help participants understand why they are nutritionally at-risk and how eating the WIC foods will help them address those risks.

Numerous studies have shown the benefits of the WIC Program. The national WIC evaluation (1986) was a set of studies funded by the federal government. Some of the benefits these studies found were: a

- Lack of training for staff and lack of staff in food stamp offices.
- Lengthy and complicated paperwork, including complex applications and monthly reporting requirements, and lack of assistance in completing paperwork.
- Vehicle asset limitation.
- Inadequate benefits when compared to the time and expense incurred in the application and verification process.

Options to Expand Participation

- Restore funding for outreach.
- Revise the Thrifty Food Plan to reflect a nutritionally adequate diet.
- Simplify the application and verification procedure.
- Raise the asset limit.
- Address stigma by projecting more positive image of using food stamps.

"SPECIAL DIETARY USE" LABEL STATEMENTS

This regulation defines the term "special dietary use," thus emphasizing that ordinary foods, even those containing added vitamins and minerals, will be labeled under Nutrition Labeling. It establishes the U.S. Recommended Daily Allowances (U.S. RDA) as the official standard for nutrition labeling, and specifies the U.S. RDA for various vitamins and minerals.

The regulation clarifies the status of vitamin K, choline, potassium, sodium, and sulfur, pointing out that these are recognized as essential in human nutrition. It says "These nutrients are not appropriate for addition to general purpose foods or dietary supplements of vitamins and minerals," but may be added to certain Special Dietary Foods which are the sole item of a diet or are used under a physician's care.

The regulation prohibits six claims:

1. That a food, because of the presence or absence of certain vitamins and/or minerals, is adequate or effective for the prevention, treatment, or cure of any disease.
2. That a balanced diet of ordinary foods cannot supply adequate amounts of nutrients.
3. That the lack of optimum quality of a food because of the soil on which it is grown, may be responsible for an inadequacy or deficiency in the quality of the daily diet.
4. That the storage, transportation, processing, or cooking of a food may be responsible for an inadequacy or deficiency of the daily diet.
5. That a food has dietary properties when they are of no significant value in human nutrition. This prohibits the mixing of rutin, other bioflavonoids, para-aminobenzoic acid, inositol and similar substances with vitamins or minerals.
6. That a natural vitamin in a food is superior to an added or synthetic vitamin, or that there is a difference between vitamins naturally present, and those that have been added.

These regulations do not preclude a manufacturer or distributor who has adequate scientific data from claiming a higher nutrient retention in his product than in a competitive product. Nor do they prohibit a claim that a particular food has a higher nutrient content because of the soil in which it is grown if that claim is backed up by scientific data. The regulations permit a manufacturer to identify which vitamins are naturally present and which are added to his product.

LABELING FOR CHOLESTEROL AND FA

This regulation allows consumers to identify foods for inclusion in physician-recommended fat-modified diets. It accomplishes that objective by allowing use on the label of statement of cholesterol content, stated in milligrams per serving and in milligrams per 100 grams of food, and the listing of the amounts of fats in grams per serving in two categories: polyunsaturated and saturated. The total fat content as a percentage of the total number of calories in the food will also be listed.

If cholesterol or fatty acid information is used, full nutrition labeling must be provided, and the label must contai the following statement:

"Information on fat (and/or cholesterol) content is pr vided for individuals who, on the advice of a physician, ar modifying their total dietary intake of fat (and/or choles terol)."

The labeling does not mean that FDA is taking a positio on the medical debate surrounding the role of fat consum tion in persons with heart disease. The regulation is an attempt to make it easier for consumers to select foo products useful in fat-modified diets.

FOOD FACTS I

* SHELF-LIFE PRICING LAW. Connecticut has a law which says that retail stores cannot increase the price of food items ONCE THEY HAVE BEEN PLACED ON THE SHELF AND OFFERED FOR SALE. Of course, the store may put whatever prices it wishes on the food items BEFORE they are put out for sale. If you believe a store is violating this law, contact your LOCAL POLICE.

* UNIT PRICING LAW. This law requires all stores in Connecticut (except owner-operated, single retail stores or stores under 3500 square feet) to label their food items showing the unit of weight, measure or count for that item, the price PER UNIT and the total price. This way, you can compare not only the cost of different brands, but the cost of different sizes of products. The Unit Pricing information may be affixed to the item itself or placed on the shelf where the item is displayed for sale. Violations of this law may be reported to the Food Division of the Department of Consumer Protection at 566-3388 or toll-free at 1-800-842-2649.

* UNIVERSAL PRODUCT CODE PRICING LAW. You've probably noticed those funny looking lines-you can't decipher-on many food items. That's the Universal Product Code symbol. It's part of the supermarkets' computerized electronic scanners which speed up your checking out.

* The law requires any seller using the Universal Product Code System to mark the consumer product (which can be any commodity other that a prescription drug) with the RETAIL PRICE. This is also known as ITEM PRICING. This way, you can double-check your cash-register receipt against the individual items in your grocery bag.

(over)

* The scanners have proven to be quite accurate, based on spot-checks by the Food Division of the Department of Consumer Protection. Occasionally, you might find a discrepancy. This can be due to a lag-time between the store's marking new prices on products and punching those prices into the computer. Or you might find the store failing to mark individual items. In either case, report the problem to the store manager. You can also contact the Food Division as well at 566-3388 or toll-free at 1-800-842-2649.

For further information, contact the Food Division, Department of Consumer Protection at the above numbers.

(From State of Connecticut, Department of Consumer Protection
165 Capitol Ave.
Hartford, CT 06106 1-800-842-2649)

October 1987

The Food Stamp Program

Program Description

The Food Stamp Program is designed to improve the nutrition of low-income people by providing coupons to cover part or all of a household's food budget. The Food Stamp program was first developed in the late 1930s and has undergone many changes. Currently authorized by the Food Stamp Act of 1977, benefits are fully funded by the federal government. In 1971, Congress established uniform national standards of eligibility and required all states to inform low-income people about the availability of food stamps. In 1974, the program was expanded nationwide and all states participating had to offer food stamps in every county.

The program is administered nationally by the US Department of Agriculture (USDA) and statewide and locally by state welfare or human services agencies. Costs of the program are evenly divided by federal and state/local governments. There are 53 state agencies and 3,898 local offices. Sources of law for food stamps are Federal statutes, 7 USC Sec. 2011 et. seq.; Federal Regulations, 7 CFR Sec. 271 et. seq.; State Manuals; USDA Policy Memos; and a lengthy body of case law.

Congressional Committees with jurisdiction over the Food Stamp Program are the House Agriculture Committee and its Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition, and the Senate Committee on Agriculture, Nutrition, and Forestry and its Subcommittee on Nutrition and Investigations.

The Food Stamp Program is the nation's single most important program in the fight against hunger. It is also the only food program in America that is available to all who meet eligibility standards regardless of age or family composition. Improvements in the program are the most direct and effective way to ameliorate the problem of hunger in the U.S.

Eligibility

Eligibility is determined on the basis of a household's financial (income and resources cannot be too high) and non-financial (citizenship, social security number, work requirement) status. A household is defined as a person or a group of people living together, but not necessarily related, who buy and cook food together. The Food Stamp Program operates as an entitlement program: anyone who meets eligibility requirements is entitled to receive benefits.

For most households (except those with elderly or handicapped members), a gross income below 130 percent of the poverty line satisfies the income test. For the elderly and handicapped, gross income levels are more liberal, provided that the net income is still below 100 percent of the poverty line. The gross income guidelines for households of various sizes without elderly or handicapped members, effective July 1, 1987 to June 30, 1988, are as follows:

Gross Income Eligibility Levels for Households, Fiscal Year 1987

Household Size	Maximum Monthly Gross Income (in dollars) (130% of the Poverty Line)
1	$596
2	802
3	1008
4	1214
5	1420
6	1625
7	1831
8	2037
each additional person	+206

Most households may have up to $2,000 in countable resources (checking or savings account, cash, stocks/bonds), and households with at least one household member age 60 or older may have up to $3,000. Many resources are not countable toward these limits.

Everyone is entitled to apply for the Food Stamp Program. The application process includes filing and completing an application form, being interviewed and verifying certain information. Mandatory verification includes: identification (e.g., birth certificate or driver's license), alien status, social security number, documentation of income and resources (e.g., pay stub or bank book), and deductible expenses (e.g., lease or utility bill).

At the time of application and once every 12 months, all able-bodied household members between 18 and 60 years of age and 16 and 17 year old head of households who are not in school must register to work.

Benefits

Food stamp recipients receive monthly coupons to supplement their food purchasing power. Program benefits, based on USDA's "Thrifty Food Plan", provide an average of 50 cents a meal per person. Benefits vary by family size and according to net income. Generally, if a household has no income, they receive the maximum allotment of coupons. From there, for each $1 of income, benefits are reduced by about 30 cents.

The maximum coupon allotments, effective October 1, 1987 to September 30, 1988, are as follows:

Maximum Monthly Food Stamp Coupon Allotments (in dollars)

Household Size	48 States and D.C.	Alaska (urban)	Hawaii	Guam	V.I.
1	87	113	133	128	111
2	159	207	244	235	205
3	228	297	350	336	293
4	290	378	444	427	373
5	344	448	527	508	443
6	413	538	633	609	531
7	457	595	700	673	587
8	522	680	800	770	671
each added person	+65	+85	+100	+96	+84

Participation Levels

Average monthly participation was 19.4 million people in fiscal year 1986. Almost two-thirds of all food stamp recipients are children, elderly, or disabled. Nearly one-fifth (19.3 percent) of all food stamp recipients have earned income. In 1984, (the most current year in which data was available) 93 percent of all food stamp households had gross incomes of below the poverty level–including nearly 40 percent which had gross incomes at below half the poverty level–at the time they received benefits.

Funding

In 1981 and 1982, the Food Stamp Program endured severe budget cuts. Funding levels were partially restored by legislation in 1984 through 1986. The appropriation level for the Food Stamp Program was $12.7 billion in fiscal year 1987 (October 1, 1986 to September 30, 1987).

Barriers to Participation

- Inadequacy of the Thrifty Food Plan to provide a nutritionally adequate diet.
- Lack of information or misinformation about the program.
- Lack of accessible office sites.
- Lack of mail issuance.
- The stigma caused by prejudice and fear of being accused of fraud prevents people from participating.

NAME____________________

12. NUTRITION LABELING

According to a recent regulation of the Food and Drug Administration, all processed foods which have nutrients added or for which nutritional claims are made must provide uniform nutrition labeling.

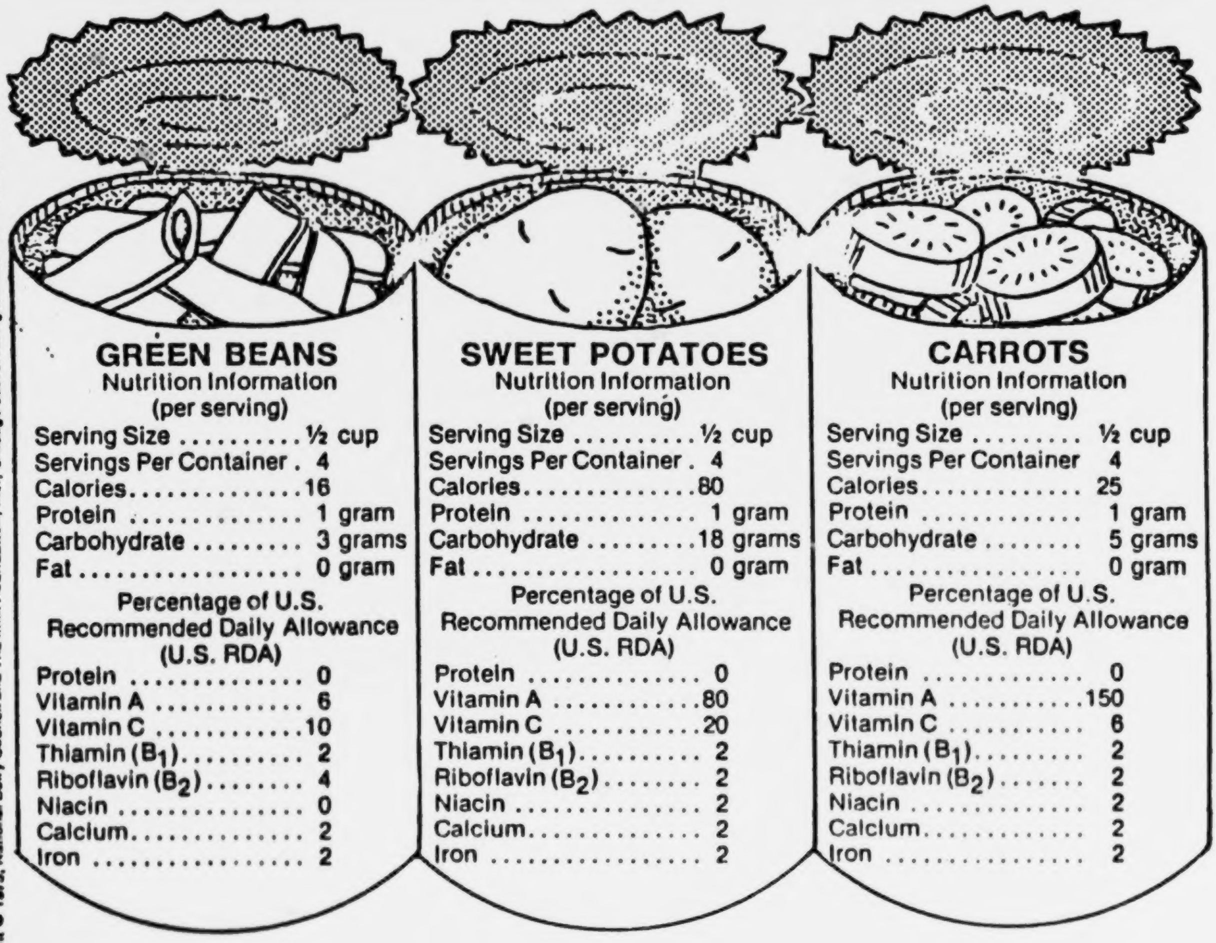
Look at the labels for three vegetables below.

Which would be a good vegetable for a low-calorie dinner? Why?____________________

Which vegetable would be best as a "quick-energy" food? Why?____________________

Which vegetable provides the highest U.S. RDA percentage of vitamin A? Vitamin C? ____________________

Sweet potatoes cost almost twice as much as green beans or carrots. Do you think the additional nutritional value is worth the additional cost? Why?____________________



	GREEN BEANS	SWEET POTATOES	CARROTS
Nutrition Information (per serving)			
Serving Size	½ cup	½ cup	½ cup
Servings Per Container	4	4	4
Calories	16	80	25
Protein	1 gram	1 gram	1 gram
Carbohydrate	3 grams	18 grams	5 grams
Fat	0 gram	0 gram	0 gram
Percentage of U.S. Recommended Daily Allowance (U.S. RDA)			
Protein	0	0	0
Vitamin A	6	80	150
Vitamin C	10	20	6
Thiamin (B_1)	2	2	2
Riboflavin (B_2)	4	2	2
Niacin	0	2	2
Calcium	2	2	2
Iron	2	2	2

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NOTE: These values were rounded from those in National Dairy Council's **Food Models.**

INFORMATIONAL ASSIGNMENT:

INTRODUCTION:

Have you ever thought about everything you must do to get ready for a meal? We usually go to the bathroom, wash hands, straighten our clothes, clear the dining area of unpleasant sights and smells, and do various other things to make mealtime a pleasant time. Our clients would like to have the same consideration when mealtime approaches. In this lesson, we will be talking about serving, feeding, and monitoring the client in ways that will make mealtime a pleasant and happy experience so that he or she will be more inclined to eat properly.

We will not discuss intravenous feedings, blood transfusions and transparenteral nutrition feedings that may be on-going in your facility or client's home.

LESSON PLAN: 28

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

OUTLINE: (Key Points)

I. Considerations Involved in Preparing a Client for Mealtime (CD-1)

A. Offer bedpan or urinal, assist to bathroom, or remind client to use the toilet facilities.

B. Wash client's hands or remind to wash hands.

C. Make sure dentures, glasses, hearing aid are cleaned and are properly in place.

D. Assist client to dining room or place of choice in home, if tolerated.

   1. Assist to chair and position at table.

   2. Protect clothing with napkin or towel--do not refer to it as a "bib."

   3. Cover unsightly medical appliances, such as urinary catheter bags.

E. If client, in a facility, is unable to go to the dining room, assist to chair, if tolerated.

   1. Position client comfortably with overbed table in convenient position.

   2. Protect clothing with napkin or towel.

F. If client is unable to get out of bed

   1. Elevate head of bed and position client in as near a sitting position as possible with overbed table in convenient position.

   2. Protect clothing with napkin or towel.

G. Prepare the surroundings of the client.

   1. Put away unsightly equipment.

   2. Remove smells of recent BM by airing room. Odors that remain indicate a cleaning problem.

3. Place fresh glass of water within reach at all times.

4. Straighten linens.

H. Provide privacy for clients who have unpleasant eating habits.

II. Preparing and Serving Food Trays

A. Check name (and room number) to make sure client, in facility, gets correct tray.

B. Check tray to make sure everything is on it according to posted menu.

C. If client cannot eat when tray is served, take it away to keep it warm.

D. Serve trays promptly so food temperature is maintained.

E. Serve on tray at a time to avoid contamination of second tray in another client's room.

F. Carry tray at waist level; not on shoulder next to hair.

G. In facility, see that each client who should have a tray receives one. If a client does not have a tray upon completion of tray pass, notify charge nurse.

H. See that the general appearance of the tray is orderly and tidy.

I. Trays must be served and clients fed promptly upon delivery of tray. (CD-2,3)

III. Assisting the Client to Eat

A. Place the tray on the table with main dish closest to the client.

B. Arrange everything so the client can reach it.

C. In facility, remove food covers and put them to one side or return them to the kitchen.

NOTE: Do not place covers on floor or utility carts.

D. Open milk cartons, cereal boxes and anything else that may be difficult for the client to manage if they require or request help.

E. Help client with cutting food, buttering bread, removing hard-cooked egg from shell, pouring liquids, etc.

F. Provide a straw for the client who is unable to use a cup.

G. Encourage clients to do as much for themselves as possible.

H. Use adaptive equipment as necessary for the client to be able to eat on his/her own. (HO 1)

1. Build up utensils
2. Plate guards
3. Band to hold utensils
4. Drinking Cup
5. Knifork
6. Swivel spoon or fork
7. Extended handles
8. Pencil clip for straw

I. Stay with client until you are certain he or she can manage independently. (CD-4)

J. Note and record amount of food eaten; report change of appetite to food supervisor and charge nurse.

K. Note foods client is not eating and report findings to food supervisor and charge nurse.

L. Report the foods not eaten by a diabetic client to the charge nurse. (CD-5)

IV. Feeding a Client

A. Place tray so client can see food.

B. Protect client and bed linens with towel or napkin.

C. NA should be in sitting position, if possible, while feeding the client.

NOTE: It is permissible to sit beside the client when feeding him/her.

D. Avoid client being rushed or hurried.

E. Describe the meal if client is unable to see it.

F. Use a straw for giving liquids, if necessary.

G. Encourage client activity--have him/her hold bread, grasp glass, etc.

H. Fill spoon half full to avoid spilling and to give manageable amounts of food.

I. Serve food in order of client's preference (provide a substitute if a particular food is not accepted).

J. Offer liquids and solids alternately to provide moisture for chewing.

K. Give client sufficient time to chew and swallow food thoroughly, as well as time to breathe between bites.

L. Season food as client wishes unless there are special diet restrictions.

M. Tell the client what each bite is as offered.

N. Warn clients when offering something hot.

O. Keep conversation friendly and discuss pleasant subjects.

P. Wipe mouth as needed and when finished.

V. After-Meal Care (CD-6)

A. Take tray away when client is finished eating. Report comments regarding food to food service supervisor/charge nurse.

B. Do not leave dirty dishes in front of client.

C. Make sure client's clothing is clean, change if soiled by spilled food.

D. Assist client from dining room/eating area to his/her room.

1. Wash face and hands.
2. Assist with or remind of mouth care.
3. Encourage participation in an activity.

E. Assist client back to bed from chair in room.

   1. Wash face and hands.

   2. Assist or give mouth care.

   3. Make comfortable and place signal light/hand bell within reach.

F. Lower backrest if client is in bed.

   1. Wash face and hands.

   2. Assist or give mouth care.

   3. Position comfortable and place signal light within reach.

G. Put personal articles where client can reach them.

H. Note how much and what the client eats. Any changes in eating habits can signal changes in physical condition--report to charge nurse.

I. Report to charge nurse how client ate.

J. Wash your hands.

VI. Clients with Special Eating Problems

A. Client with paralysis or weakness of muscles used for eating

   1. Client should be sitting in upright position to aid swallowing; gag and cough reflexes may be absent, making it easier for resident to choke.

   2. Feed into side of mouth that is not paralyzed.

   3. Remind client to think about swallowing.

   4. Give small amounts of food and allow the client plenty of time to chew.

   5. Clean out paralyzed side of mouth frequently with a swab or damp washcloth.

B. Blind client

   1. Identify everything on the tray.

   2. Identify placement of food on tray by comparing to positions of the hour hand on a clock; i.e., milk

at 2:00, meat at 6:00, etc. Placement should be the same at each meal. (HO 2)

C. Comatose, unconscious, or unresponsive client

   1. Do not give oral liquids or food.

   2. Client will often receive nutrition by another method, i.e., tube feeding.

   3. Nasogastric tube feeding for long-term nutrition performed by the nurse; note the following (HO-3)

      a. Keep head of bed elevated approx. 30o to prevent regurgitation (return of solids or fluids to the mouth from the stomach).

      b. Client needs frequent mouth care (q 2 hrs.).

      c. Keep nostrils clean.

      d. Inform nurse if tape becomes loose.

D. Client in isolation

   1. Follow facility's isolation procedure. If you don't know, ask.

   2. Paper dishes are usually used.

   3. If metal or china utensils are to be used, check with charge nurse about how they are to be handled.

   4. Special instruction in isolation techniques shall be given to the nurse assistant by an RN when this becomes necessary in a LTC facility or at home.

VII. Summary and Conclusion

   A. Considerations involved in preparing a client for mealtime

   B. Preparing and serving food trays

   C. Assisting the client to eat

   D. Feeding a client

E. After-meal care

F. Clients with special eating problems

Mealtime is very important for the client. For many, it is the highlight of his/her day, it is something that he or she looks forward to. Make it an enjoyable and pleasant experience. See that the tray is served in as attractive and sanitary a manner as possible or that the dining area is cleared. Keep in mind all of the things that need to be done for each client before and after a meal.

LESSON PLAN: 28

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. Can you name at least one thing that must be done for the client before mealtime?
2. How would your appetite be if your toast was wet from spilled coffee or the gravy was running into the applesauce?
3. How would you feel if the nurse assistant put the tray down in front of you and walked off without a smile or a hello?
4. What can you do to encourage self-help in eating?
5. Why is it significant to note what a diabetic client has not eaten?
6. What are some of the things you should do after the client has finished eating?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Have students role-play serving trays to one another and feeding each other.
3. Practice using special adaptive devices designed to help a client eat.

LESSON PLAN: 28

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

EVALUATION ITEMS:

1. List three considerations in preparing the client for a meal.

   a.

   b.

   c.

2. What are three things you will do after a client has finished a meal?

   a.

   b.

   c.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 3. The head of the bed should be elevated if the client remains in bed to eat.

_____ 4. Several trays may be served at one time to save time and energy.

_____ 5. The tray should be placed so the main dish is closest to the client.

_____ 6. The nurse assistant should sit while feeding a client if at all possible.

_____ 7. Client self-help activity should be encouraged.

_____ 8. The fork or spoon should be filled completely full when giving the client a mouthful of food.

_____ 9. All solids should be given first, then the liquids.

_____ 10. Food for clients on regular diets; foods should be seasoned as the client wishes.

_____ 11. No conversation should take place during the meal.

SUBSTITUTIONS

DAIRY SUBSTITUTIONS

½ cup evaporated milk plus ½ cup water	1 cup whole milk
¼ cup powdered whole milk plus 1 cup water	1 cup whole milk

EGG SUBSTITUTION

2 egg yolks	1 whole egg (for thickening custards and puddings)

LEAVENINGS SUBSTITUTIONS

¼ teaspoon baking soda plus ½ teaspoon cream of tartar	1 teaspoon baking powder
½ teaspoon baking soda plus 2 tablespoons vinegar	1¼ teaspoons baking powder

CHOCOLATE SUBSTITUTION

3 tablespoons cocoa plus 1 tablespoon shortening	1 square (1 ounce) unsweetened chocolate

---

_____ 12. The tray should be taken away as soon as the client finishes eating.

_____ 13. When the meal is finished personal articles should be placed where the client can reach them.

_____ 14. Foods not eaten should be noted and reported.

_____ 15. The client should be fed as fast as possible.

_____ 16. Food should be served in order of client's preference.

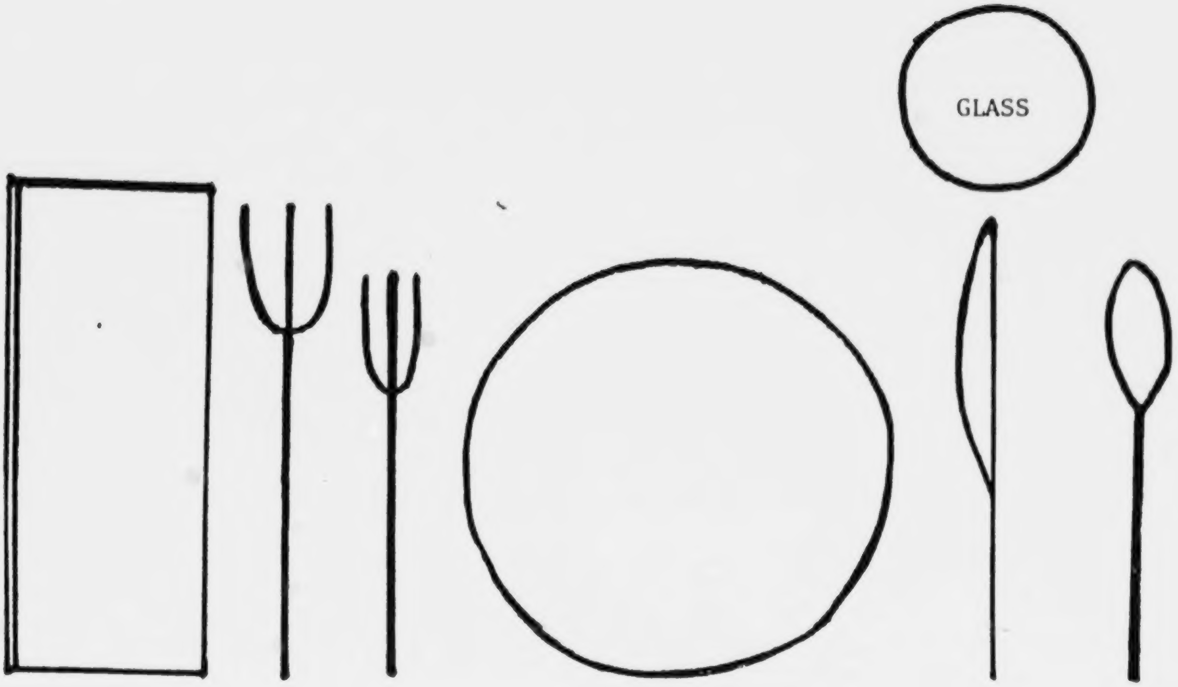
_____ 17. A paralyzed client should be fed into the paralyzed side of the mouth.

_____ 18. Identify where everything is on the tray of a blind client.

_____ 19. Regular dishes are always used for the client in isolation.

20. Describe how you could tell the blind client where his/her food is located.

TABLE SETTING



LESSON PLAN: 28

COURSE TITLE: NURSE ASSISTANT

UNIT V: FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: V-28 OR DEMONSTRATION:

SERVING, FEEDING AND MONITORING
(Lesson Title))

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Discuss three considerations involved with preparing clients for mealtime.
2. Explain how to prepare and serve food trays.
3. Recognize key points in assisting the client to eat.
4. Identify key points in feeding a client.
5. List and explain three considerations of after meal care.
6. Identify key points in meeting nutritional needs of clients with special eating problems.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Adaptive Equipment
2. HO 2: Food Tray for the Blind Client with Correct Table Setting
3. HO 3: Nasogastric Tube
4. Trainex filmstrip: "Feeding the Patient"
5. Projector

e. Assist client back to bed from chair in room.
    1. Wash face and hands.
    2. Assist or give mouth care.
    3. Make comfortable and place signal light within reach.

f. Lower backrest if client is in bed.
    1. Wash face and hands.
    2. Assist or give mouth care.
    3. Position comfortably and place signal light within reach.

g. Put personal articles where client can reach them.

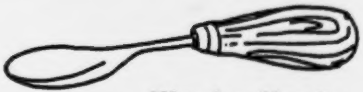
h. Note how much and what the client eats. Any changes in eating habits can signal changes in physical condition--report to charge nurse.

i. Report to charge nurse how client ate.

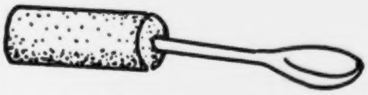
j. Wash your hands.

3. T
4. F
5. T
6. T
7. T
8. F
9. F
10. T
11. F
12. T
1e. T
14. T
15. F
16. T
17. F
18. T
19. F
20. When feeding the blind client you should first identify every item on the tray. Inform the client of the placement of food on the tray by comparing each item to a position of the hour hand on a clock. Placement should be the same at each meal.

BUILT-UP HANDLES

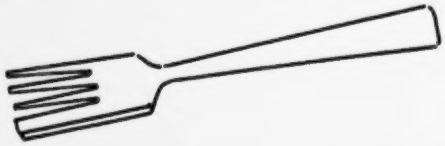


Wooden Handle



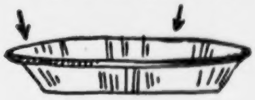
Foam Curler

CUTTER FORK (Knifork)

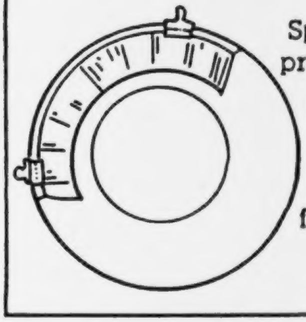


RIM ON PLATE

One-third section of disposable pie tin.



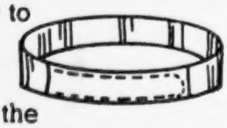
Attach to plate by paper clamps.

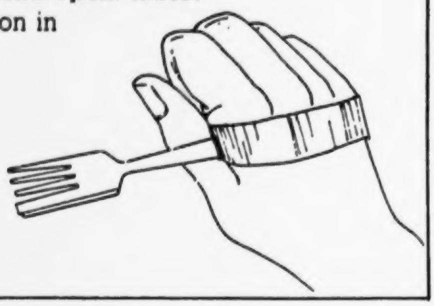


Spilling food is prevented. The rim provides a surface to assist in filling the fork or spoon.

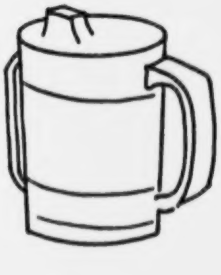
ELASTIC HOLDER

Measure 3/4 inch elastic to fit snugly around the hand. Stitch a 3 inch section of soft leather to the elastic - making a snug pocket. Leave one end open. Insert fork or spoon in open end.

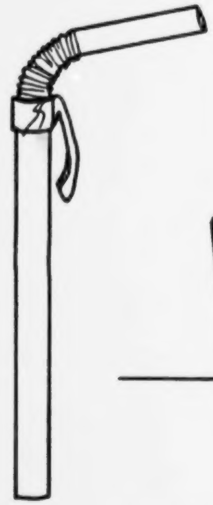


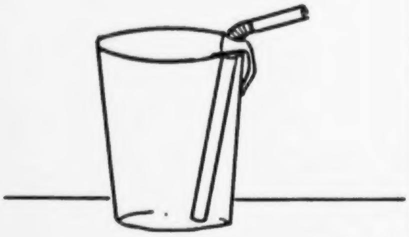


DRINKING CUP

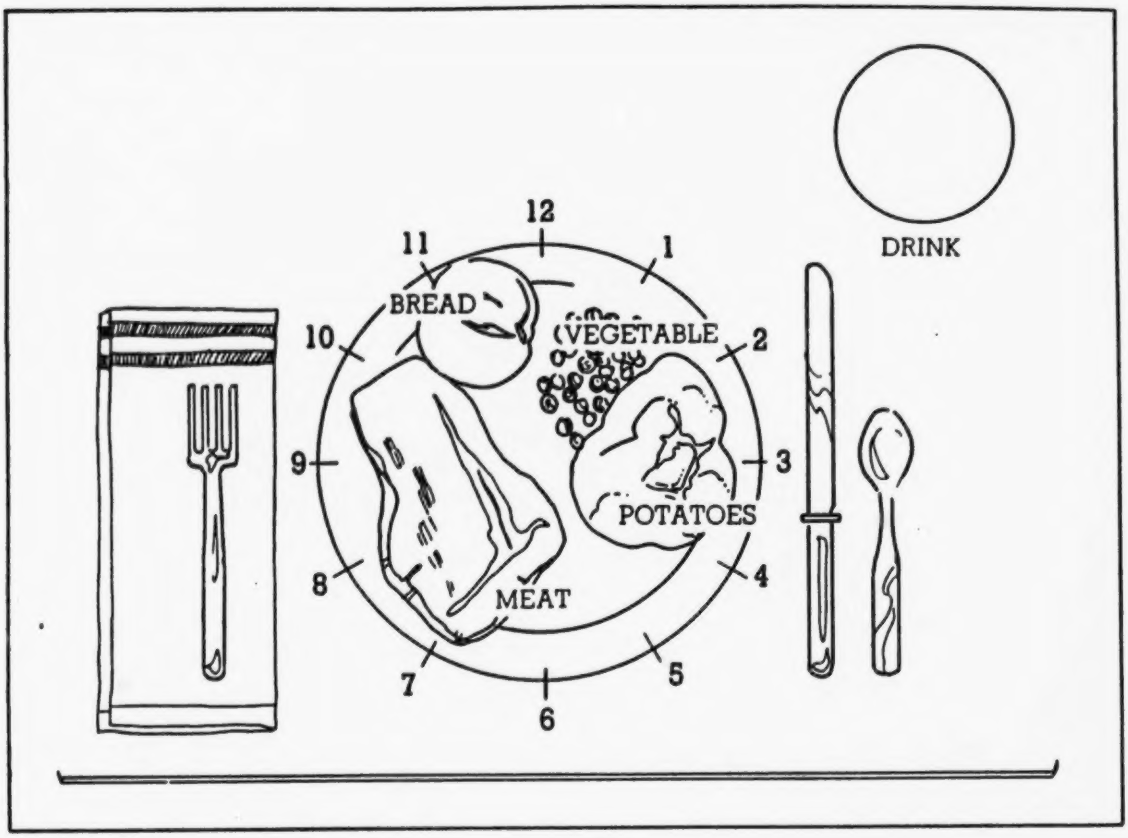


PENCIL-CLIP TO FASTEN STRAW TO GLASS





FOOD TRAY FOR THE BLIND CLIENT


12
1
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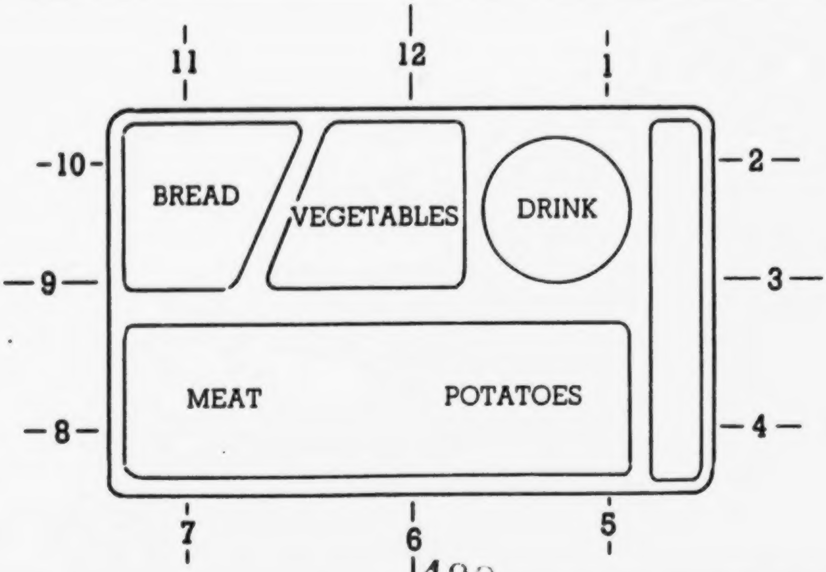
BREAD
VEGETABLE
POTATOES
MEAT
DRINK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BREAD
VEGETABLES
DRINK
MEAT
POTATOES

423

LESSON PLAN: 29

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: OR DEMONSTRATION: V-29

FEEDING THE HELPLESS CLIENT
(Lesson Title))

LESSON OBJECTIVE - THE STUDENT WILL BE ABLE TO:

1. Demonstrate the procedure for feeding a helpless client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Food tray
2. Napkin or towel
3. Overbed table
4. Chair

DID THE STUDENT	YES	NO
15. Alternate liquids and solids.		
16. Wipe client's mouth as needed.		
17. Warn client when giving something hot.		
18. Take tray away as soon as resident is finished.		
19. Note foods and amounts eaten		
20. Provide after-meal care.		
21. Wash hands.		
22. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "FEEDING THE HELPLESS CLIENT" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 28

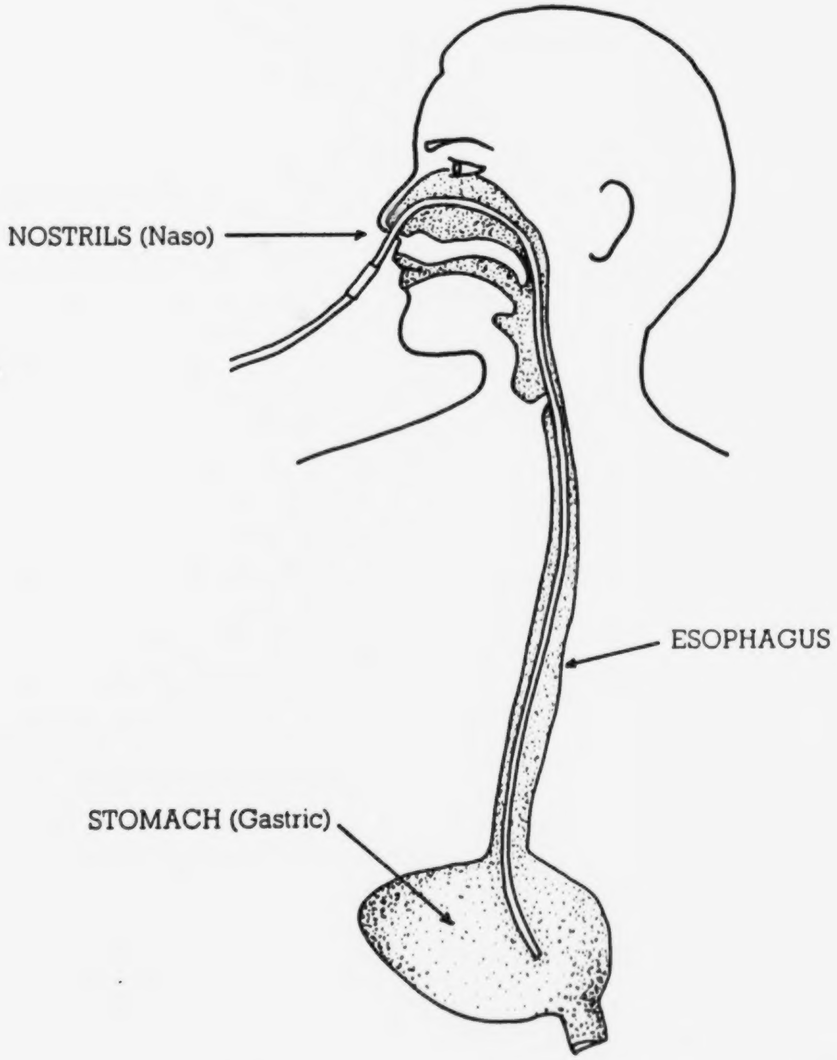
COURSE TITLE: NURSE ASSISTANT

UNIT V: FOOD AND NUTRITION

ANSWERS TO EVALUATION ITEMS:

1. The student may list any three of the following:
   a. Offer bedpan or urinal, assist to bathroom, or remind client to go to the bathroom.
   b. Wash client's hands or remind to wash hands.
   c. Make sure dentures, glasses, hearing aid are cleaned and are properly in place.
   d. Assist to dining room, if tolerated.
      1. Assist to chair and position at table.
      2. Protect clothing with napkin or towel--do not refer to it as a "bib."
      3. Cover unsightly medical appliances, such as urinary catheter bags.
   e. If client is unable to go to the dining room, assist to chair, if tolerated.
      1. Position client comfortably with overbed table in convenient position.
      2. Protect clothing with napkin or towel.
   f. If client is unable to get out of bed
      1. Elevate head of bed and position client in as near a sitting position as possible with overbed table in a convenient position.
      2. Protect clothing with napkin or towel.
   g. Prepare the surroundings of the client.
      1. Put away unsightly equipment.
      2. Remove smells of recent BM by airing room. Odors that remain indicate a cleaning problem.
      3. Place fresh glass of water within reach.
      4. Straighten linens.
   h. Notify charge nurse if client appears to be in pain or complains of pain.
   i. Avoid giving treatments immediately before and after meals.
   j. Provide privacy for clients who have unpleasant eating habits.
2. The student may list any three of the following:
   a. Take tray away when client is finished eating. Report comments regarding food to food service supervisor.
   b. Do not leave dirty dishes in front of client.
   c. Make sure client's clothing is clean, change if soiled by spilled food.
   d. Assist client from dining room to his/her room.
      1. Wash face and hands.
      2. Assist with or remind of mouth care.
      3. Encourage to participate in activity.

NASOGASTRIC TUBES (Stomach Tubes)


NOSTRILS (Naso)
ESOPHAGUS
STOMACH (Gastric)

TEACHER RESOURCES:

INTRODUCTION:

You have been studying basic nutrition, meal planning, shopping for food and meal preparation and how to serve, feed, and monitor a client. With that background information you are now ready to learn the actual procedure for feeding a client. For clients, the food and mealtime is the highlight of their day. They wish to be fed in an acceptable manner as if they could do so themselves. Let's find out how!

LESSON PLAN: 29

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

STEPS OF PROCEDURE:

1. Wash your hands. (CD-1)
2. Provide before-meal care: offer client bedpan or urinal; wash client's hands and face; position client in sitting position.
3. Wash your hands.
4. Check food tray before serving to make sure it is the correct one.
5. Place food tray in front of client on table or overbed table.
6. Explain that you will help client eat.
7. Spread napkin or towel to protect clothes and linen.
8. Sit down in chair facing client.
9. Prepare food: cut up meat, butter bread, pour tea or coffee, etc.
10. Season food as client wishes within diet guidelines.
11. Ask client in what order he/she wants his/her food served; name each mouthful of food as you offer it. (CD-2)
12. Let client help self if possible.
13. Use straws or a double handled cup for liquids.
14. Give small bites and feed slowly allowing time for chewing, swallowing and breathing.
15. Alternate liquids and solids. (CD-3)
16. Wipe client's mouth as needed.
17. Warn client when giving something hot.
18. Take tray away as soon as client is finished.
19. Note foods and amounts eaten.

20. Provide after-meal care: wash client's hands and face; remove napkin; make client comfortable; place call light or hand bell within reach.

21. Wash your hands.

22. Record observations.

    NOTE: Report anything unusual to charge nurse.

SUMMARY AND CONCLUSION:

1. Classroom Discussion

2. Review steps of procedure.

When you have completed study of the steps of procedure, you will practice on each other in the classroom-laboratory or on a client in th facility under the supervision of a licensed nurse.

LESSON PLAN: 29

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. Why should the nurse assistant wash his/her hands before serving the tray?
2. Why should the client be encouraged to do what he/she can during a meal?
3. What is the purpose of alternating liquids and solids?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students practice feeding one another. Try using baby food at room temperature--it will stress the need for serving food promptly and demonstrate to students what it's like to eat food with no salt or sugar. Have some students slouch down in their chairs and try to eat. Have some students eat with eyes closed or while blindfolded and be fed with little explanation of what they are being fed.

LESSON PLAN: 29

COURSE TITLE: NURSE ASSISTANT

UNIT V **:** FOOD AND NUTRITION

EVALUATION ITEMS: **NAME OF STUDENT:** ____________________

FEEDING THE HELPLESS CLIENT

EQUIPMENT

1. Food tray
2. Napkins or towel
3. Overbed table
4. Chair

DID THE STUDENT	YES	NO
1. Wash hands.		
2. Provide before-meal care.		
3. Wash hands.		
4. Check food tray before serving to make sure it is the correct one		
5. Place food tray in front of client on table; overbed table.		
6. Explain that he/she will help client eat.		
7. Spread napkin or towel.		
8. Sit down in chair facing client.		
9. Prepare food.		
10. Season food as client wishes within diet guidelines.		
11. Ask client in what order he/she wants his/her food served, name each mouthful of food as it is offered.		
12. Let client help self if possible.		
13. Use straws or a double handled cup for liquids.		
14. Give small bites and feed slowly allowing time for chewing, swallowing and breathing.		

LESSON PLAN: 30

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: OR DEMONSTRATION: V-30

FEEDING BY MOUTH WITH A SYRINGE OR FEEDER
(Lesson Title))

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate the procedure for feeding a client using a syringe according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Syringes/feeder
2. 40-50 cc bulb syringe or feeder (120 c.c.)
3. Liquid feeding material
4. Overbed table/table
5. Napkin or towel

17. Record observations.

NOTE: Report anything unusual to charge nurse.

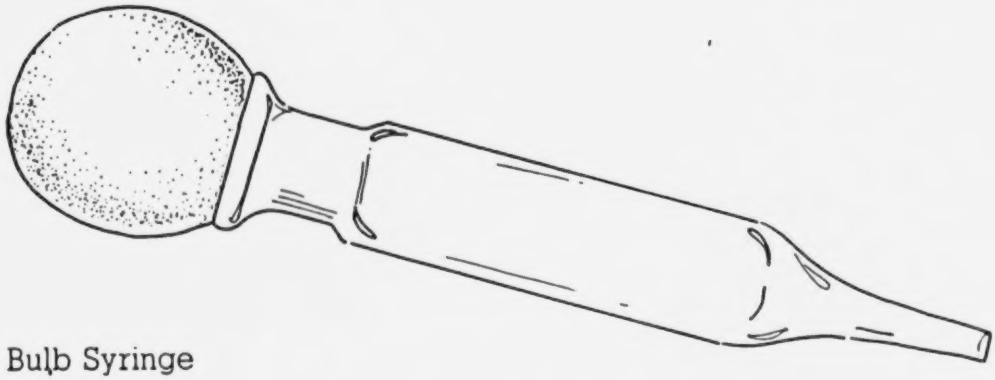
SUMMARY AND CONCOUSION:

1. Classroom discussion.
2. Review steps of procedure.

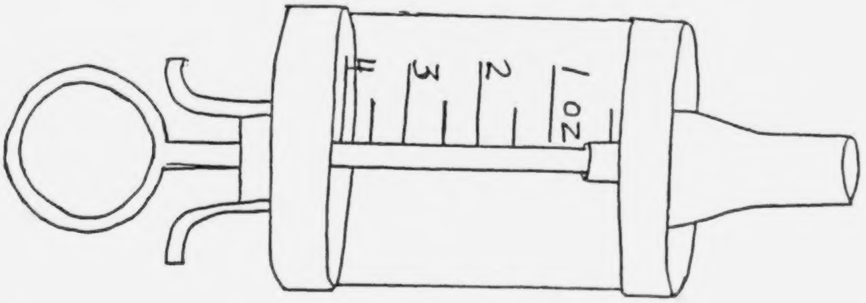
After you have studied the steps of procedure, you will practice on each other in the classroom/laboratory or on a client in the facility under the supervision of a licensed nurse according to your facility's or agency's policy.

TYPES OF SYRINGES

HO 1



Bulb Syringe



Feeder

TEACHER RESOURCES:

INTRODUCTION:

There are times when a client may be able to swallow but not chew. Instead of starting IV therapy or using a nasogastric tube, we may be able to maintain adequate nutrition by feeding the client semi-liquid and liquid foods with a bulb or plunger-type syringe or feeder.

LESSON PLAN: 30

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

STEPS OF PROCEDURE:

1. If feeding is premixed and kept in the refrigerator, remove it at least 30 minutes before serving or warm it slightly. CD-1

2. Wash your hands.

3. Provide before-meal care: offer client bedpan or urinal; wash client's hands and face; position client in sitting position.

4. Wash your hands.

5. Obtain food tray and assemble necessary equipment.

6. Inform client what you will be doing.

7. Protect client's clothing with a towel or napkin.

8. Fill bulb syringe by depressing bulb end; fill feeder by pulling back on plunger.

9. Insert syringe tip into side of mouth.

   NOTE: If client is paralyzed, place on non-affected side. CD-2

10. Slowly squeeze bulb or depress plunger, giving no more than 15 cc at a time. CD-3

11. Feed slowly. Allow time for client to swallow.

12. Wipe client's mouth frequently.

13. Clean up supplies and remove syringe/feeder and food containers to dietary department for sanitization.

14. Note how much client has eaten.

15. Provide after-meal care: wash client's face and hands; remove napkin; make client comfortable; place call light within reach.

16. Wash your hands.

LESSON PLAN: 30

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. Why should the food be at room temperature?
2. Why would you place the syringe in the nonparalyzed side of the paralyzed client's mouth?
3. What might happen if you gave more than 15 cc at one time?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students how much 15 cc is using a medicine cup. Have students drink 15 cc of fluid and 30 cc and discuss the difference in amounts to be swallowed.
2. Practice feeding each other with a bulb syringe/feeder.

LESSON PLAN: 30

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

EVALUATION ITEMS: NAME OF STUDENT: ______________________

FEEDING BY MOUTH WITH A SYRINGE/FEEDER

EQUIPMENT

1. 40-50 cc bulb syringe or plunger-type feeder
2. Liquid feeding material
3. Overbed table/table
4. Napkin or towel

DID THE STUDENT	YES	NO
1. If feeding is premixed and kept in the refrigerator remove it at least 30 minutes before serving or warm it slightly.		
2. Wash hands.		
3. Provide before-meal care.		
4. Wash hands.		
5. Obtain food tray and assemble necessary equipment.		
6. Inform client what he/she will be doing.		
7. Protect client's clothing with a towel or napkin.		
8. Fill bulb syringe by depressing bulb end; fill plunger-type feeder by pulling back on plunger.		
9. Insert syringe tip into side of mouth.		
10. Slowly squeeze bulb or depress plunger-type feeder no more than 15 cc at a time.		
11. Feed slowly. Allow time for client to swallow.		
12. Wipe client's mouth frequently.		
13. Clean up supplies and remove syringe and food containers to dietary department for sanitization.		
14. Note how much client has eaten.		

DID THE STUDENT	YES	NO
15. Provide after-meal care.		
16. Wash hands.		
17. Record observations and report everything unused to charge nurse.		

The student has satisfactorily completed the procedure "FEEDING BY. MOUTH WITH A SYRINGE OR FEEDER" according to the steps outlined.

____
Instructor's Signature
(Verifying Satisfactory Completion)

____
Date

444

LESSON PLAN: 31

COURSE TITLE: NURSE ASSISTANT

UNIT V: FOOD AND NUTRITION

SCOPE OF UNIT:

This unit covers the basics of nutrition with background information on meal planning, shopping for food, meal preparation as well as serving, feeding and monitoring all types of clients' intake of food and fluids. The steps of procedure cover feeding the helpless client, feeding a client using a bulb syringe or patient feeder and measuring and recording of fluid intake and output.

INFORMATION TOPIC: V-31 OR DEMONSTRATION:

OBSERVE, MEASURE, AND RECORD FLUID INTAKE AND OUTPUT
(Lesson Title))

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. List three routes to administer fluids.
3. Identify key points in measuring intake and output.
4. List four fluids which must be measured
5. Transfer household measurement equivalents to cubic centimeters.
6. Define what is meant by the term "force fluids."
7. Identify four methods of forcing fluids.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Graduate Measures
2. HO 2: Measuring and Recording Fluid Intake and Output
3. HO 3: Fluid Intake and Output Record
4. HO 4: Distributing Drinking Water
5. Graduate measure
6. Intake-output sheet

TEACHER RESOURCES:

INTRODUCTION:

Since our bodies are 60% water, this liquid is absolutely essential to life. As a nurse assistant, one of your responsibilities will be to make sure your clients have enough fluids. In order to help you meet the needs of your clients, we will be discussing what to observe, how to measure and how to record the intake and output of fluids for your clients.

LESSON PLAN: 31

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Diaphoresis - excessive sweating

   B. Graduate - a container marked with lines for measuring liquids (HO 1)

II. Routes to Administer Fluids

   A. Oral

   B. Intravenous (IV) - into the vein

   C. Nasogastric tube or gastrostomy tube - into the stomach CD-1)

III. Measurement of Intake and Output

   A. Average oral intake for an adult is 2,000 to 3,000 cc of fluid per day, which is approximately 2 to 3 quarts. Output should be about the same.

   B. Physician may restrict or encourage fluid intake; it is the charge nurse's responsibility to know which has been ordered and to pass this information on to the NA.

   C. When intake and output (I&O) is ordered, accuracy is very important and the client and his/her family should be informed of the procedure. (HO 2, HO 3)

   D. Paper and a pencil are usually kept at the client's bedside for each eight hour shift to record I&O.

   E. Checking and recording liquid intake at mealtime and between meals is a nursing responsibility.

   F. Intake and output are totaled and recorded at the end of each shift and at the end of the 24 hour period.

   G. At mealtime, check client's tray before serving and after client has eaten to determine intake of liquids, remember that foods which turn liquid if allowed to stand at room temperature are also counted.

H. Before emptying the water pitcher, measure water that is left to determine the amount which has been taken.

I. Observe client for signs of dehydration or edema. (See Lesson 26, V.B.5.) (CD 2 & 3)

J. Measure urinary output accurately each time bedpan, urinal, specipan, or bedside commode are emptied using an accurate graduate.

K. Measure and record any other body discharges such as vomitus, diarrhea, or fluid in suction apparatus and drainage on dressings; mention diaphoresis on I&O record if client perspires profusely.

NOTE: If unable to measure accurately, estimate amount and record estimated amount on chart.

L. Measure fluids in a rigid container; catheter bags are not always accurate, drain into a graduate then observe and record output.

M. When looking at a transparent graduate, read it at eye level.

N. If the client is incontinent, record the number of times on the I&O sheet.

IV. Fluids Which Must be Measured for Oral Intake

A. Water, coffee, tea, broth, ice chips, gelatin

B. Juices, carbonated beverages (soda)

C. Ice cream, milk shakes, sherbet, milk, cream

V. Measurement Equivalents from Household to Cubic Centimeters (cc)

A. 1 ml = 1 cc

B. 1 tsp = 5 cc

C. 1 oz = 30 cc

D. 1 cup (8 oz) = ? cc

1. If 1 oz = 30 cc then 8 oz would = 240 cc

2. Can be applied to any amount (CD-4)

VI. Force Fluids

A. Means taking in more than the usual number of drinks

B. Elderly may take less because:

1. Fluid not being readily available or placed within reach
2. Afraid of dribbling urine
3. Afraid of having to get up and go to urinate at night
4. Difficulty holding a glass, pouring liquid from pitcher, etc.

C. How to force fluids:

1. Place fluids within reach.
2. Offer small amounts frequently.
3. Offer a variety of fluids.
4. Encourage foods with high fluid content (pudding, watermelon).
5. Offer favorite beverages.
6. Offer fluids at frequent intervals when client is unable to obtain fluids by himself/herself.
7. If goal has been set, assist client to reach it during time set.
8. Explain that dribbling sometimes results from concentrated urine, infection, or irritation. Therefore, more fluids are needed.
9. Check client during night and assist to bathroom as needed; provide a night light.

VII. Summary and Conclusion

A. Terms and definitions

b. Routes to administer fluids

C. Measurement of intake and output

D. Fluids which must be measured for oral intake

E. Measurement equivalents from household to cubic centimeters

F. Force fluids

This lesson has shown you the importance of fluids and has prepared you to identify those fluids that must be recorded as intake and output. You should now be ready to accurately identify and measure fluids.

LESSON PLAN: 31

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

CLASSROOM DISCUSSION:

1. What is the nurse assistant's responsibility with regard to tube feedings?

2. What do you think are some signs of dehydration?

3. Do you remember the signs of edema?

4. If a client drank a glass of juice which contained 3 ounces, how many cc's would you record as input on the I&O sheet?

   What if the client took in 6 ounces of fluid, how many cc's would that be?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Demonstrate how to read a graduate; have all students read various amounts of fluid.

2. Have students fill out an I&O sheet using HO 2 and HO 3.

3. Using a variety of containers that hold liquid, have students estimate c.c., if full. Place water to various levels in each container. Have students estimate how much fluid in each, how much a client had taken in if utensil had been full, and prove answer by measuring liquid left in containers.

4. Unknown to students, place a measured amount of water on a cloth. Have students estimate how much fluid was absorbed by cloth.

LESSON PLAN: 31

COURSE TITLE: NURSE ASSISTANT

UNIT V : FOOD AND NUTRITION

ANSWERS TO EVALUATION ITEMS:

1. Diaphoresis means excessive sweating.

2. A graduate is a container marked with lines for measuring liquids.

3.
   a. Oral
   b. Intravenous (IV)
   c. Nasogastric tube or gastrostomy tube

4. The student may list any four of the following:
   a. Water
   b. Coffee
   c. Tea
   d. Broth
   e. Ice Chips
   f. Gelatin
   g. Juices
   h. Carbonated beverages (soda)
   i. Ice Cream
   j. Milk shakes
   k. Sherbert
   l. Milk
   m. Cream

5. Force fluid means taking in more than the usual number of drinks.

6. The student may list any four of the following:
   a. Place fluids within reach.
   b. Offer small amounts frequently.
   c. Offer a variety of fluids.
   d. Encourage foods with high fluid content (pudding, watermelon).
   e. Offer favorite beverages
   f. Offer fluids at frequent intervals when resident is unable to obtain fluids by himself/herself.
   g. If goal has been set, assist resident to reach it during time set.
   h. Explain that dribbling sometimes results from concentrated urine, infection, or irritation. Therefore, more fluids are needed.
   i. Check residents during night and assist to bathroom as needed; provide a night light.

7. F

8. F

9. T

10. T

11. F

12. F

13. 1

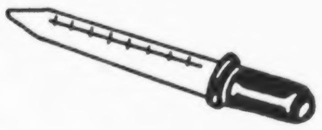
14. 5

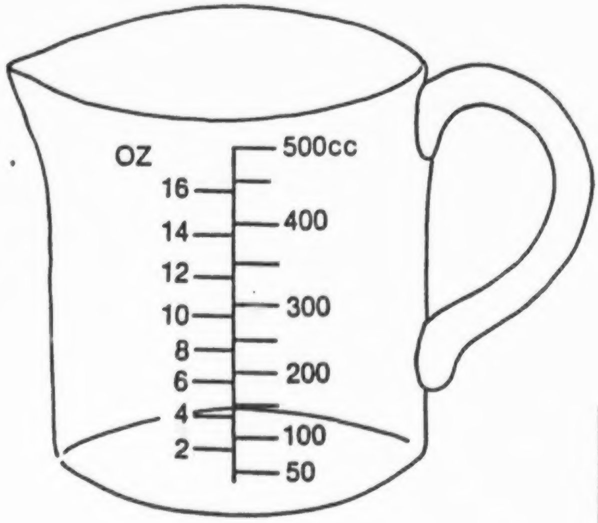
15. 1

16. 120

GRADUATE MEASURES

HO 1

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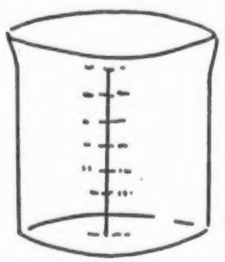

MEASURING AND RECORDING FLUID INTAKE & OUTPUT HO 2

Directions: Use the intake and output chart on the following page. Put the following information in the proper column and total the figures. Compute the intake and output.

A.	Date - May 11		
B.	Name - John Middleman, Jr.		
C.	South Wing: Room 255		
D.	Method of Administration: Oral		
E.	7:30 a.m.	Urine	500cc.
	8:00 a.m.	Grape juice Milk Coffee	90cc. 120cc. 90cc.
	9:30 a.m.	Water	180cc.
	12:00 Noon	Tea Soup	120cc. 180cc.
	1:00 p.m.	Water	90cc.
	1:15 p.m.	Urine	300cc.
	2:00 p.m.	Apple juice	120cc.
	2:15 p.m.	Vomitus	120cc.
	3:20 p.m.	Tea	120cc.
	5:00 p.m.	Orange juice	60cc.
	5:30 p.m.	Urine	400cc.
	6:30 p.m.	Water	150cc.
	8:45 p.m.	Gingerale	150cc.
	9:00 p.m.	Urine	300cc.
	10:00 p.m.	Water	90cc.
	10:15 p.m.	Urine	200cc.

FLUID INTAKE & OUTPUT RECORD

HO 3

VALLEY VIEW MANOR

FLUID INTAKE and OUTPUT RECORD

Name: ______________________________ Room: ______________

INTAKE					OUTPUT			
Date	Time	Method Admin.	Solution	Amount Rec'd	Time	Urine Amount	Others	
							Kind	Amt.
TOTAL					TOTAL			

1 Ounce = 30 cc 8 oz. Glass = 240 cc 4 oz. Juice Glass = 120 cc *4 oz. Soup Bowl = 120 cc

6 oz. Cup = 180 cc *Jello-4 oz. = 120 cc

*Measure servings in each facility to establish accurate measure.

DISTRIBUTING DRINKING WATER

I. Introduction

A. Purpose is to assure that fresh water is at the bedside of client at all times; thus it is passed at regular intervals during the day.

B. Drinking glasses and pitcher are collected daily and sent to the dietary department where they are sanitized through a dishwashing process.

II. Equipment

A. Ice Scoop

B. Pitchers

C. Trays

D. Cart

E. Glasses

III. Procedure

A. Wash your hands.

B. Check which clients may not have water.

C. Check which clients do not care for or are not allowed ice.

D. Collect pitchers, glasses, and trays from bedside of clients and place on cart or tray.

E. Take cart or tray of equipment to dietary department.

F. Obtain clean pitchers and glasses.

G. Fill some of the pitchers 1/3 full with ice; use ice tongs or a large scoop to handle ice.

H. Add water to fill pitchers

I. Return pitchers promptly to client's bedside table.

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LESSON PLAN: 32

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-32 OR DEMONSTRATION:

PERSONAL CARE FOR THE CLIENT

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Identify activities that make up personal care.
3. Recognize key points involved in providing personal care.
4. Identify adaptive measures that may be necessary to take when giving personal care to clients with special conditions.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #397: "Personal Care"
2. Projector

TEACHER RESOURCES:

INTRODUCTION:

Personal care is very important to everyone. Think of all we do to improve our looks. The client requires the same care; and you, as a nurse assistant, must either see that the client does these things, assist with them, or complete them for the client. In order to maintain the dignity of the individual, the client must be helped to look as good as possible. This lesson will introduce what procedures make up personal care, as well as some basic principles to follow.

LESSON PLAN: 32

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

OUTLINE: (Key Points)

I. Terms and Definitions

   A. Aspiration - to draw a foreign substance into lungs when breathing in

   B. Gangrene - death of tissue usually due to deficient or absent blood supply

II. Activities of Personal Care (CD-1)

   A. Bathing

      1. Bed bath

      2. Tub bath

      3. Shower

   B. Bedmaking

      1. Unoccupied

      2. Occupied

   C. Oral hygiene - mouth care

   D. Shaving

   E. Skin care

   F. Hair care

   G. Nail care

   H. Dressing and undressing

III. Points to Remember When Performing Personal Care Activities

   A. Wash your hands before and after a procedure.

   B. Assemble all equipment needed before starting a procedure.

   C. Use only the client's own personal care items.

D. Greet the client by name and identify yourself.

E. Give thorough explanations of what you are going to do. (CD-2)

F. Respect privacy of client. (CD-3)

   1. Announce your presence before entering a client's closed unit by knocking or requesting permission to enter.

   2. Close doors.

   3. Pull curtains.

   4. Cover with bath blanket.

G. Allow the client to perform any part of the procedure he/she is able to; inability to perform personal care means a loss of independence for the client.

H. Use good body mechanics.

   1. Bend at the knees.

   2. Use arm and leg muscles.

I. Remember safety factors.

   1. Prevent falls, use non-skid mat or towel in tub or shower.

   2. Prevent burns, always check temperature of water with the inside of your forearm or wrist before using on the client.

   3. Lock shower chairs, geri chairs, w/c when not using to push client.

J. Provide warmth.

   1. Bath blanket prevents chilling before and after bath.

   2. Children and elderly are more prone to chilling.

   3. Keep door shut to shower room to conserve heat and avoid drafts.

K. Make observations using the four methods of observation.

   a. See

LESSON PLAN: __31__

COURSE TITLE: NURSE ASSISTANT

UNIT __V__: FOOD AND NUTRITION

EVALUATION ITEMS:

1. Define the term diaphoresis.

2. Define the term graduate.

3. List three routes to administer fluids.

   a.

   b.

   c.

4. List four fluids which must be measured for oral intake.

   a.

   b.

   c.

   d.

5. What does force fluids mean?

6. List four methods of forcing fluids.

   a.

   b.

   c.

   d.

For each of the following,f write "T" if the statement is true, or "F" if it is false.

_____ 7. The average adult should take in about 5,000 cc's of fluid per day.

_____ 8. Restricted fluids will never be ordered by a physician.

______ 9. Anything that will turn to liquid at room temperature is to be measured.

______ 10. Liquid stools, vomitus, drainage from wounds are all considered as output.

______ 11. Dehydration is excess amounts of fluid in the tissue.

______ 12. It is not important to record output if a client is incontinent since you cannot actually measure it.

Fill in the blanks.

13. 1 ml = ______ cc

14. 1 tsp = ______ cc

15. ______ oz = 30 cc

16. 4 oz = ______ cc

b. Smell

c. Hear

d. Touch

IV. Adaptive Measures for Special Conditions

A. The unconscious client (CD-4)

1. Client cannot respond but still needs to be given an explanation.
2. Get assistance to move the client.
3. Do not give oral fluids when performing mouth care, to prevent choking or aspiration of fluid into the lungs.
4. Leave client positioned in proper body alignment.
5. Check every one and one half to two hours for incontinence.

B. The paralyzed client

1. Handle affected side with care, support joints.
2. Do not leave on affected side very long -- may cause swelling.
3. Maintain proper positioning for good circulation.

C. The diabetic client (CD-5)

1. Good skin care is necessary, observe the skin for breakdown or tears and report to the charge nurse.
2. Feet and legs are susceptible to poor circulation. Shoes may also cause reduced circulation.
3. NEVER trim the toenails of a diabetic client. If skin is nicked it may become infected leading to gangrene and eventual amputation.
4. Diabetic's wounds heal more slowly due to poor circulation.

V. Summary and Conclusion

A. Terms and definitions

B. Activities of personal care

C. Points to remember when performing personal care activities

D. Adaptive measures necessary for special conditions

You will spend most of your hours at work carrying out these personal care activities. Remember you are with the client more than anyone else of the health care team. You are the eyes, ears, and nose for him/her--make pertinent observations and meet the client's emotional needs during this time, too. Do not concentrate only on the physical aspects of the care.

FOOD EXCHANGE LIST

IMPORTANT ! 1 gram of PROTEIN = 4 CALORIES; 1 gram of CARBOHYDRATE = 4 CALORIES: 1 gram of FAT= 9 CALORIES

Foods that Need Not be Measured

(Insignificant carbohydrate or calories)
- Coffee
- Tea
- Clear broth
- Bouillon (fat free)
- Lemon
- Gelatin (unsweetened)
- Rennet tablets
- Cranberries (unsweetened)
- Mustard (dry)
- Pickle (unsweetened)
- Saccharin and other noncaloric sweeteners
- Pepper and other spices
- Vinegar
- Seasonings

The following may be used to season food: chopped parsley, mint, garlic, onion, celery salt, nutmeg, mustard, cinnamon, pepper, and other spices; lemon, saccharin, and vinegar. These may be used freely.

List 1 Milk Exchanges

One exchange of milk contains 8 gm. of protein, 10 gm. of fat, 12 gm. of carbohydrate, and 170 calories.

This list shows the different types of milk to use for one exchange:

Type of Milk	Amount
Whole milk (plain or homogenized)	1 c.
*Skim milk	1 c.
Evaporated milk	1/2 c.
Powdered whole milk	1/4 c.
*Powdered skim milk (nonfat dried milk)	1/4 c.
Buttermilk (made from whole milk)	1 c.
*Buttermilk (made from skim milk)	1 c.

One type of milk may be used instead of another. For example, 1/2 cup of evaporated milk can be substituted for 1 cup of whole milk.

*Skim milk and buttermilk have the same food values as whole milk, except that they contain less fat. Add 2 fat exchanges to the meal when 1 cup of skim milk or buttermilk made from skim milk is used.

List 2 Vegetable Exchanges: Group A

Group A contains little protein, carbohydrate, or calories. As much as 1 cup at a time may be used without counting it.

- Asparagus
- *Broccoli
- Brussels sprouts
- Cabbage
- Cauliflower
- Celery
- *Chicory
- Cucumbers
- *Escarole
- Eggplant
- *Greens
  - Beet greens
  - Chard
  - Collards
  - Dandelion
  - Kale
  - Mustard
  - Spinach
  - Turnip greens
- Lettuce
- Mushrooms
- Okra
- *Pepper
- Radishes
- Sauerkraut
- String beans, young
- Summer squash
- *Tomatoes
- *Watercress

*These vegetables contain a lot of vitamin A

List 2 Vegetable Exchanges: Group B

Each exchange contains 2 gm. of protein, 7 gm. of carbohydrate and 35 calories.

1/2 c. of vegetable equals 1 exchange.

- Beets
- *Carrots
- Onions
- Peas, green
- Pumpkin
- Rutabagas
- *Squash, winter
- Turnip

*These vegetables contain a lot of vitamin A.

List 3 Fruit Exchanges

One exchange of fruit contains 10 gm. of carbohydrate and 40 calories. This list shows the different amounts of fruits to use for one fruit exchange.

	Amount
Apple (2" diam.)	1 small
Applesauce	1/2 c.
Apricots, fresh	2 medium
Apricots, dried	4 halves
Banana	1/2 small
Blackberries	1 c.
Raspberries	1 c.
*Strawberries	1 c.
Blueberries	2/3 c.
*Cantaloupe (6" diam.)	1/4
Cherries	10 large
Dates	2
Figs, fresh	2 large
Figs, dried	1 small

List 3 (continued)

	Amount
*Grapefruit	1/2 small
*Grapefruit juice	1/2 c.
Grapes	12
Grape juice	1/4 c.
Honeydew melon	1/8 medium
Mango	1/2 small
*Orange	1 small
*Orange juice	1/2 c.
Papaya	1/3 medium
Peach	1 medium
Pear	1 small
Pineapple	1/2 c.
Pineapple juice	1/3 c.
Plums	2 medium
Prunes, dried	2 medium
Raisins	2 tbsp.
*Tangerine	1 large
Watermelon	1 c.

*These fruits are rich sources of vitamin C. One of them should be included each day.

List 4 Bread Exchanges

One exchange contains 2 gm. of protein, 15 gm. of carbohydrate and 70 calories.

This list shows the different amounts of foods to use for one bread exchange.

	Amount
Bread	1 slice
Biscuit, roll (2" diam.)	1
Muffin (2" diam.)	1
Cornbread (1 1/2" cube)	1
Cereals, cooked	1/2 c.
Dry, flake and puff types	3/4 c.
Rice, grits, cooked	1/2 c.
Spaghetti, noodles, cooked	1/2 c.
Macaroni, etc., cooked	1/2 c.
Crackers, graham (2 1/2" square)	2
Oyster (1/2 c.)	20
Saltines (2" square)	5
Soda (2 1/2" square)	3
Round, thin (1 1/2")	6
Flour	2 1/2 tbsp.
Vegetables	
Beans and peas, dried, cooked (lima, navy, split pea, cowpeas, etc.)	1/2 c.
Baked beans, no pork	1/4 c.
Corn	1/3 c.
Popcorn	1 c.
Parsnips	2/3 c.

List 4 (continued)

	Amount
Potatoes, white	1 small
Potatoes, white, mashed	1/2 c.
Potatoes, sweet, or yams	1/4 c.
Sponge cake, plain (1 1/2" cube)	1
Ice cream (omit 2 fat exchanges)	1/2 c.

Use these foods carefully because they have a lot of sugar.

List 5 Meat Exchanges

One meat exchange contains 7 gm. of protein, 5 gm. of fat and 75 calories. This list shows the different amounts of foods to use for one meat exchange:

	Amount
Meat and poultry (medium fat) beef, lamb, pork, liver, chicken, etc.	1 oz.
Cold cuts (4 1/2" x 1/8") salami, minced ham, bologna, liverwurst, luncheon loaf	1 slice
Frankfurter (8-9 per lb.)	1
Egg	1
Fish: haddock, etc.	1 oz.
Salmon, tuna, crab, lobster	1/4 c.
Shrimp, clams, oysters, etc.	5 small
Sardines	3 medium
Cheese: Cheddar type	1 oz.
Cottage	1/4 c.
*Peanut butter	2 tbsp.

*Limit peanut butter to 1 exchange a day unless the carbohydrate in it is allowed in the patient's meal plan.

List 6 Fat Exchanges

One fat exchange contains 5 gm. of fat and 45 calories.

This list shows the different foods to use for one fat exchange.

	Amount
Butter or margarine	1 tsp.
Bacon, crisp	1 slice
Cream, light	2 tbsp.
Cream, heavy	1 tbsp.
Cream cheese	1 tbsp.
Avocado (4" diam.)	1/8
French dressing	1 tbsp.
Mayonnaise	1 tsp.
Oil or cooking fat	1 tsp.
Nuts	6 small
Olives	5 small

Fig. 23.5 Meal planning with exchange lists for the diabetic patient

From GERIATRICS, A Study of Maturity, by Caldwell and Hegner
Delmar Publishers, 1975

HO 1

LESSON PLAN: 32

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. Aspiration - to draw a foreign body into lungs when breathing in.
2. Gangrene - death of tissue due to deficient or absent blood.
3. c
4. T
5. F
6. T
7. T
8. T
9. F
10. T
11. T

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-33 OR DEMONSTRATION: VI-33

BED BATH
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List four purposes of bathing.
2. Describe the difference between a complete bed bath and a partial bed bath.
3. Recognize five specific measures related to bathing.
4. Demonstrate performing a complete bed bath according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Bath Mitten
2. HO 2: Soaking the Foot
3. Trainex filmstrip #369: "Bed Bath"
4. TLC filmstrip: "How to Give Your Patient a Bed Bath"
5. Projector
6. Bath basin
7. Soap and soap dish
8. Bath towels (2)

9. Face towel
10. Deodorant
11. Washcloths (2)
12. Bath Blanket
13. Lotion
14. Powder (optional)
15. Laundry bag/linen hamper
16. Clean bed linen
17. Gown or pajamas
18. Equipment for oral hygiene
19. Equipment for shaving
20. Equipment for hair care
21. Equipment for nail care
22. Client's toiletries, cosmetics

TEACHER RESOURCES:

INTRODUCTION:

A bed bath is given to any client unable to get out of bed for whatever reasons. During the bed bath other personal care procedures are also performed, as well as changing of the bed linens. This type of bath gives the nurse assistant a great opportunity for head-to-toe observation, as well as ample time to communicate with the client. It is also a good time to identify any concerns or needs of the client that may be unnoticed during the usual hustle and bustle of the day. The nurse assistant should be aware that the client may feel frustrated and embarrassed with having to depend on someone else for a very personal activity. Treat the client with dignity and respect.

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Bathing

- A. A clean body in necessary for one to feel good about oneself.
- B. Purpose of bathing:
    1. Promote cleanliness and comfort
    2. Stimulate circulation
    3. Relax the client
    4. Observe the condition of the client's body
- C. A client should be bathed at the following times:
    1. Any time he/she is incontinent, provide a partial bath as needed.
    2. If the client is continent and without odor problems, bathe at lease twice a week.
- D. A complete bed bath involves washing the entire body.
- E. A partial bed bath involves washing the:
    1. Face
    2. Hands
    3. Underarms
    4. Genital areas.

II. Specific Measures Related to Bathing

- A. Offer the bedpan/urinal before starting the bath procedure because warm water can stimulate the urge to urinate.
- B. Use a washcloth mitten to avoid dangling ends which allow water to drip onto the clients. (HO-1)

C. Change water when it becomes soapy, cold, or dirty. Clean, fresh water is necessary to clean the client.

D. Do not leave soap in water. Use a soap dish to prevent the bath water from becoming too soapy.

E. Rinse all soap from skin, to prevent drying of the skin.

F. Washing the farthest extremity first prevents dripping water across the part you have already cleaned.

G. Place the client's hands and feet in a basin of water (if client is able). This is relaxing, makes the client feel cleaner, and helps to soften the nails. Nail care may be done at this time. (HO 2)

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for a Bed Bath

A. Steps beginning procedure

1. Wash your hands.
2. Arrange necessary equipment (laundry bag next to bed and lotion container in warm water).
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Assist with oral hygiene and shaving (if applicable).
7. Offer bedpan/urinal; then empty clean, and put it away.
8. Wash your hands.

B. Bed bath procedure

9. Place client in supine position near the side of the bed nearest you, if tolerated.
10. Untuck bed linens.
11. Remove bedspread and blanket; fold and place on chair if reusing, otherwise place in laundry bag.
12. Cover top sheet with bath blanket. Ask client to hold bath blanket in place; if unable, tuck under client's shoulders.
13. Remove top sheet without disturbing bath blanket and place in laundry bag.
14. Remove client's gown or pajamas.
15. Fill bath basin 2/3 full of warm water (115 degrees Fahrenheit).

16. Place face towel across client's chest.

17. Make mitten of washcloth (HO 1) and wet with water; squeeze out excess.

18. Wash eyes first. Start at inner corner and work out. Use different area of mitten for each eye.

19. Wash face with soap if client agrees, rinse and dry.

20. Using soap for rest of procedure, wash, rinse, and dry ears and then neck.

21. Expose arm farthest from you; place bath towel under arm up to .

22. If client is able, place basin of water on bed and immerse client's hand in water and wash.

23. Wash and rinse shoulder, axilla and arm of extremity farthest away.

24. Remove basin and dry arm and shoulder.

25. Repeat steps 21-24 with arm closest to you.

26. May do fingernail care at this point.

27. Place towel across chest and fold bath blanket to waist.

28. Wash and rinse chest and breast of female while lifting towel; expose chest of male.

29. Dry skin thoroughly.

NOTE: If female, apply a thin layer of powder into the palm of your hand and pat on skin under the breast.

30. Fold bath blanket to pubic area--keep chest covered with towel,

31. Wash, rinse and dry abdomen. Remove towel and cover with bath blanket.

32. Change bath water in basins.

33. Expose the farthest leg; flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.

34. Place basin on towel and put foot into it, if applicable. NOTE: Support leg at knee joint with your hand. (HO 2)

35. Wash and rinse leg and foot.

36. Remove basin of water and dry leg and foot.

    NOTE: Dry thoroughly in between toes with folded towel.

37. Repeat steps 33-36 on closer leg; cover client with bath blanket.

38. May do toenail care at this point if facility or H.H.C.A. allows more than cleaning under nails with orange wood stick.

39. Place towel and washcloth in laundry bag and get clean ones.

40. Change bath water in basins.

41. Ask or assist client to turn on side with back facing you.

42. Fold bath blanket over client's side to expose back and buttocks; place towel parallel to client's back.

43. Wash, rinse and dry back and buttocks.

44. Give back rub using warmed lotion.

    NOTE: Provide special attention to bony areas.

45. Remove towel and turn client to back; place towel under buttocks.

46. If client is able, provide washcloth, soap and towel and instruct him/her to wash and dry perineal (peri) area.

47. If client is unable, wash peri area from front to back. NOTE: Use disposable gloves.

48. Wash hands and if client did own peri care provide fresh water for client to wash hands.

49. Apply lotion and deodorant.

50. Put a clean gown or pajamas on client without exposing him/her.

        51. Comb hair, apply cosmetics if applicable.

    C. Steps ending procedure

        52. Remove, clean and store equipment.

        53. Wash your hands.

        54. Make the client comfortable; place call signal within reach.

        55. Record observations.

            NOTE: Report anything unusual to charge nurse.

IV. Summary and Conclusion

    A. Key points of bathing.

    B. Specific measures related to bathing.

    C. Classroom discussion.

    D. Review steps of procedure.

LESSON PLAN: 32

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. What personal care activities do you perform every day for yourself when you get up in the morning?
2. Why is it important to give explanations to the unconscious client?
3. What measures can you take to respect the privacy of a client?
4. Why shouldn't you give the unconscious client oral fluids?
5. Why do diabetic clients' wounds heal slower?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.

LESSON PLAN: 32

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. Define the term aspiration.

2. Define the term gangrene.

3. Personal care of the client in a long-term care facility includes all of the following except: (Circle the letter of the correct answer.)

   a. Shaving
   b. Hair care
   c. Clean client's room (this may be done by the H.H.A.)
   d. Oral hygiene

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 4. You should always wash your hands before and after performing a procedure.

______ 5. If you cannot locate the client's comb, it is okay to borrow his/her roommate's comb.

______ 6. Use good body mechanics by bending at the back and using your back muscles.

______ 7. Always lock shower chairs when not pushing client.

______ 8. Always greet the client by name and identify yourself before performing a procedure.

______ 9. It is appropriate to give the unconscious client sips of water when giving mouth care.

______ 10. Do not leave a paralyzed client on the affected side for over an hour because it may cause swelling to that side.

______ 11. The diabetic client needs good skin care to his/her feet and legs since he/she is more prone to poor circulation.

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. Explain how to prevent exposure during the bath procedure.
2. What can be used if no soap dish is available?
3. When should you change the bath water?
4. Why do you wash the farthest extremity first?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrips.
2. Instructor demonstrates bed bath procedure.
3. Students practice bed bath procedure.

LESSON PLAN: ___33___

COURSE TITLE: __NURSE ASSISTANT__

UNIT__VI__: __PERSONAL CARE__

EVALUATION ITEMS:

1. List the four purposes of bathing a resident.

   a.

   b.

   c.

   d.

2. Explain the difference between a complete bed bath and a partial bed bath.

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 3. Warm water applied to the skin during a bath can make a resident feel like he/she has to urinate.

______ 4. A washcloth mitten is used as a restraint for the client's hand during a bed bath.

______ 5. Soap left on the skin has a moisturizing effect.

______ 6. Washing the farthest extremity first prevents dripping water across the part you have already cleaned.

______ 7. Soaking the hands and feet in the basin of water is relaxing to the resident as well as making him/her feel cleaner.

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. a. Promote cleanliness and comfort
   b. Stimulate circulation
   c. Relax the resident
   d. Observe condition of the resident's body

2. A complete bed bath involves washing the entire body and a partial bed bath involves washing the face, hands, underarms, and genital area.

3. T
4. F
5. F
6. T
7. T

LESSON PLAN: 33

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________

BED BATH

EQUIPMENT:

1. Bath basin
2. Soap and soap dish
3. Bath towels(2)
4. Face towels
5. Washcloths
6. Bath blanket
7. Lotion
8. Deodorant
9. Powder (optional)
10. Laundry bag/linen hamper
11. Clean bed linen
12. Gown or pajamas
13. Equipment for oral hygiene
14. Equipment for shaving
15. Equipment for hair care
16. Equipment for nail care
17. Resident's toiletries, makeup

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
6. Assist with oral hygiene and shaving (if applicable).		
7. Offer bedpan/urinal, then empty, clean and put it away.		
8. Wash hands.		
B. Bed bath procedure		
9. Place client in supine position near the side of the bed nearest him/her if tolerated.		

	YES	NO
10. Untuck bed linens.		
11. Remove bedspread and blanket, fold and place on chair if reusing; otherwise place in laundry bag.		
12. Cover top sheet with bath blanket. Ask client to hold bath blanket in place; if unable, tuck under client's shoulders.		
13. Remove top sheet without disturbing bath blanket, place in laundry bag.		
14. Remove client's gown or pajamas.		
15. Fill bath basin 2/3 full of warm water (115 degrees Fahrenheit)		
16. Place face towel across client's chest.		
17. Make mitten of washcloth and wet with water; squeeze out excess.		
18. Wash eyes first. Start at inner corner and work out. Use different area of mitten for each eye.		
19. Wash face, rinse, and dry. Determine if client wants soap to be used.		
20. Wash, rinse, and dry ears and then neck.		
21. Expose arm farthest from him/her. Place bath towel under arm up to axilla.		
22. If client is able, place basin of water on bed and and immerse client's hand in water and wash.		
23. Wash and rinse shoulder, axilla and arm of extremity farthest away.		

	YES	NO
39. Place towel and washcloth in laundry bag and get clean ones.		
40. Change bath water in basin.		
41. Ask or assist client to turn on side with back facing him/her.		
42. Fold bath blanket over client's side to expose back and buttocks; place towel parallel to client's back.		
43. Wash, rinse and dry back and buttocks.		
44. Give back rub using warmed lotion, paying special attention to bony areas.		
45. Remove towel and turn client to back; place towel under buttocks.		
46. If client is able, provide washcloth, soap and towel and instruct him/her to wash and dry peri area.		
47. If client is unable, wash peri area from front to back, using gloves.		
48. Wash hands and if client did own peri care provide fresh water for client to wash hands.		
49. Apply lotion and deodorant.		
50. Put a clean gown or pajamas on client without exposing him/her.		
51. Comb hair, apply cosmetics if applicable.		

	YES	NO
C. Steps ending procedure		
52. Remove, clean and store equipment.		
53. Wash hands.		
54. Make the client comfortable; place call signal within reach.		
55. Record observations, reporting anything unusual to charge nurse.		

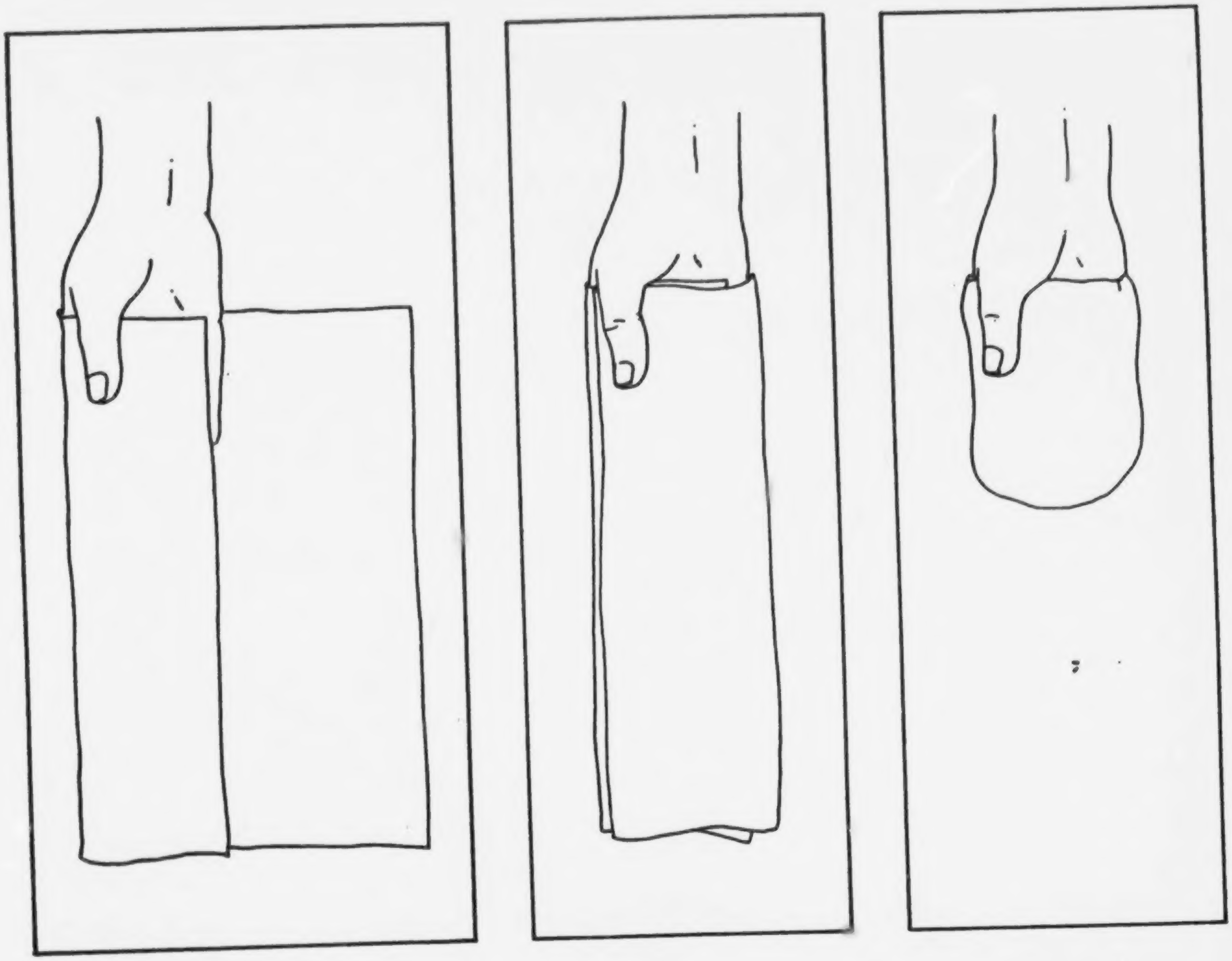
The student has satisfactorily completed the procedure "BED BATH" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Complettion)

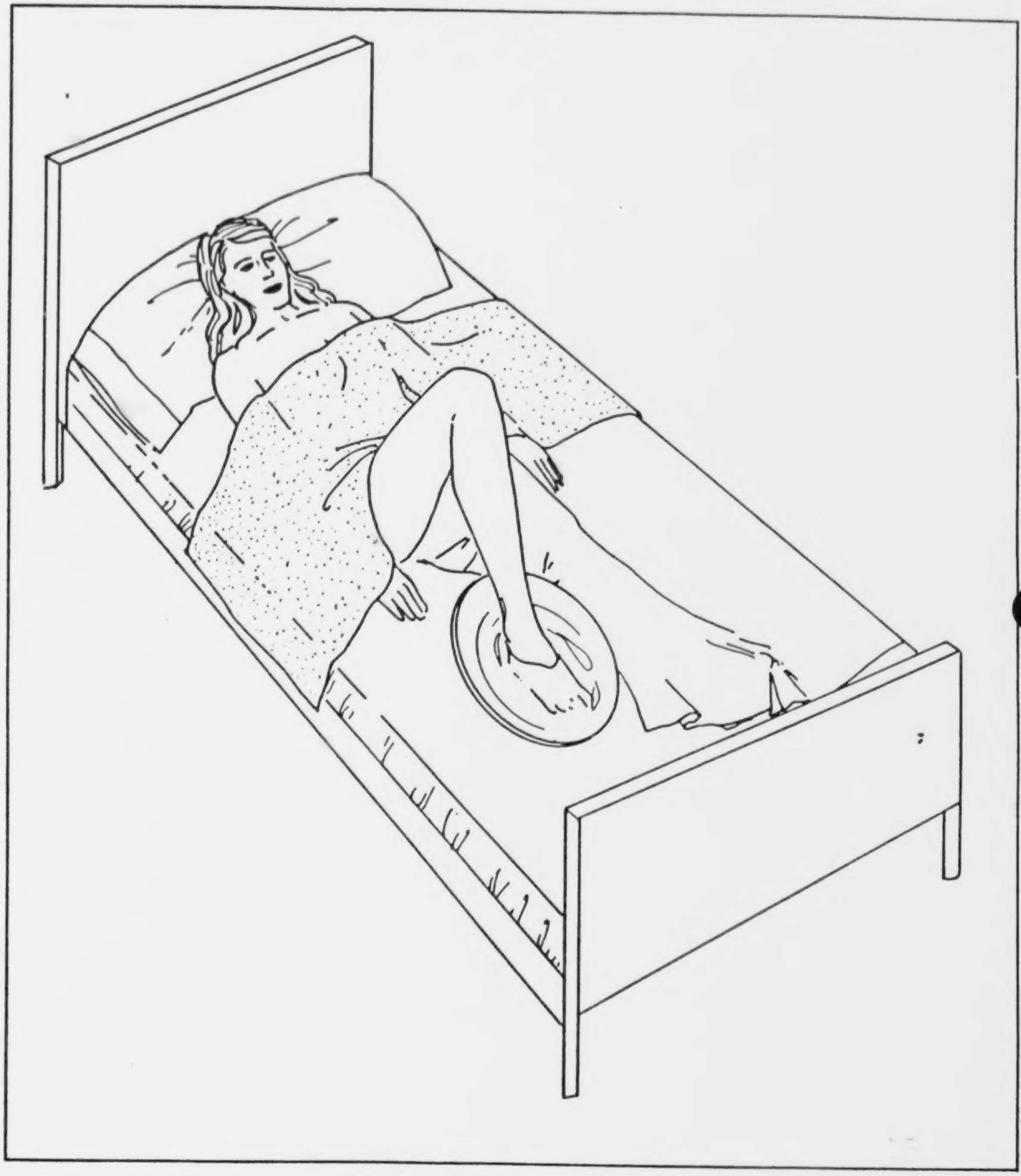
Date

BATH MITTEN

HO 1



SOAKING THE FOOT



LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-34 OR DEMONSTRATION: VI-34

TUB BATH AND SHOWER BATH
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Recognize three safety measures to take while giving a tub bath.

2. Recognize three safety measures to take while giving a shower bath.

3. Demonstrate how to give a tub bath according to the steps of procedure.

4. Demonstrate how to give a shower bath according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #122: "Shower and Tub Bath"
2. Projector
3. Bath towels (2)
4. Washcloths (2)
5. Bath blanket
6. Soap and soap dish
7. Bath thermometer, if available
8 Tub/shower chair and chair by side of tub
9. Disinfectant solution and cleaning cloth
10. Non-skid bathtub mat (use a towel if not available)
11. Bath floor mat
12. Clean clothes
13. Personal care items: lotion or powder
14. Shower cap (optional)

TEACHER RESOURCES:

INTRODUCTION:

A tub or shower may be given depending on the client's mobility and personal preference. Encourage the client to assist with the bathing if he/she is able. This can promote feelings of independence and provide some active range of motion exercise. If the type of bath assigned to the client does not seem appropriate, consult with the charge nurse and identify the reasons why another type of bath may be better for the client.

Again, this is a prime time for the nurse assistant to make observations about the total needs (physical, emotional, and social) of the client. The bath should be pleasurable experience. Keep in mind the importance of maintaining the client's dignity and respect his/her privacy.

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Tub Bath

A. Reasons for giving a tub bath

1. The tub bath is for clients who can get out of bed but may not like showers.

2. The tub bath can provide greater relaxation than a bed bath and give a feeling of being cleaner.

B. Safety Measures (CD-1)

1. The tub should be filled with an adequate amount of warm water (105 degrees Fahrenheit) to cleanse the client; however, keep in mind the client's safety.

2. The client usually stays in the tub for 10-15 minutes; longer would allow the water to cool, resulting in the client becoming cold.

3 Do not add bath oil to the water. This makes the surface of the tub slippery.

4. When a client is agile (able to move without difficulty; nimble), he/she may be left alone in the bathtub--check several times. The door should never be locked.

NOTE: If you have any doubts about the client's safety in the tub, stay with him/her.

5. If the client becomes faint while giving a tub bath: (CD-2)

a. Call for help.

b. Drain the water out of the tub.

c. Lower the head as much as possible.

d. Cover the client with a bath blanket.

NOTE: Fainting is caused by the warm water dialating the blood vessels of the skin, increasing amount of blood in the skin area and decreasing the blood flow the the brain, resulting in the client feeling faint.

6. If you are giving a whirlpool bath, follow the basic tub bath procedure and your facility's specific policies regarding whirlpool equipment safety.

II. Key Points of Shower Bath

A. Reasons for giving a shower

1. The shower is the bath of choice for many of the residents because of poor mobility and difficulty in getting in and out of the bathtub.

2. Showers with long extension hoses are very good for thorough cleansing and for stimulating circulation.

B. Safety Measures

1. Adequately cover the client when transporting him/her to the shower room to avoid changes in body temperature and unnecessary exposure.

2. Hang the shower nozzle on the handrail or hook. Do not allow it to rest on the floor.

   NOTE: The floor is always considered dirty.

3. Check shower chair wheels prior to using for sticking or wobbling, as well as locking mechanism that works.

4. The client in a shower chair should be placed facing the door of the shower stall while the NA gives the shower; this assures better control of client should he/she be difficult to manage or become faint.

5. The shower should have temperature regulator and pressure of flow regulator.

6. Should the client become faint while giving a shower:

   a. Call for help.

   b. Turn off the water.

   c. If the client is standing, have him/her sit down.

   d. Lower his/her head as much as possible.

   e. Cover with a bath blanket.

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	YES	NO
24. Remove basin and dry arm and shoulder.		
25. Repeat steps 21-24 with arm closest to him/her.		
26. Perform fingernail care.		
27. Place towel across chest and fold bath blanket to waist.		
28. Wash and rinse chest and breast of female while lifting towel. (Male-remove towel)		
29. Dry skin thoroughly. Apply powder under female client's breasts.		
30. Fold bath blanket to pubic area--keep chest covered with towel.		
31. Wash, rinse and dry abdomen. Remove towel and cover with bath blanket.		
32. Change bath water in basins.		
33. Expose the farthest leg; flex (bend) leg and place bath towel lengthwise under the leg up to the buttocks.		
34. Place basin on towel and put foot into it, if applicable. Support leg at knee joint with hand.		
35. Wash and rinse leg and foot.		
36. Remove basin of water and dry leg, foot, and between toes.		
37. Repeat steps 33-36 on closer leg. Cover client with		
38. Perform toenail care. (See 38 in Steps of Procedure for Bed Bath).		

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

TUB BATH AND SHOWER BATH

EQUIPMENT:

1. Bath towels
2. Washcloths (2)
3. Bath blanket
4. Soap and soap dish
5. Bath thermometer, if available.
6. Tub/shower chair and chair by side of tub
7. Disinfectant solution and cleaning cloth
8. Non-skid bathtub mat (use towel if not available)
9. Bath floor mat
10. Clean clothes
11. Personal care items: lotion or powder
12. Shower cap (optional)

DID THE STUDENT	YES	NO
Tub Bath		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment.		
3. See that tub/shower room is free from drafts, preferably 75-80 degrees Fahrenheit.		
4. Clean bathtub/shower chair with disinfectant solution and rinse well.		
5. Place non-skid mat, towel, or tub chair in bathtub.		
6. Place floor mat next to bathtub.		
7. Place a chair next to tub.		
8. Identify and greet client. Identify self.		

DID THE STUDENT	YES	NO
23. Apply powder, lotion and deodorant, if applicable. towel.		
24. Assist with dressing.		
C. Steps ending procedure		
25. Return client to his/her room; assist with any personal care such as shaving, nail care, hair care, etc.		
26. Make client comfortable; place call signal within reach.		
27. Return to tub room, remove soiled articles and clean tub with disinfectant solution.		
28. Wash hands.		
29. Record observations, reporting anything unusual to charge nurse.		
Shower Bath		
A. Steps beginning procedure		
1-4. Complete steps 1-4 of bath procedure.		
5. Place non-skid mat in shower stall if client is standing during shower.		
6. Identify and greet client. Identify self.		
7. Explain what he/she is going to do.		
8. Offer toileting.		

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bed making, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-35 OR DEMONSTRATION: VI-35

BEDMAKING (UNOCCUPIED/OCCUPIED)
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe the difference between an unoccupied and occupied bed.
2. Recognize three key points related to bedmaking.
3. Demonstrate making an unoccupied bed according to the steps of procedure.
4. Demonstrate making an occupied bed according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:
1. HO 1: Making a Mitered Corner and Toe Pleat
2. HO 2: Putting on the Pillowcase
3. Trainex film #476 "Basic Bed Making for Patient Comfort and Safety".
4. Trainex film #370: "Occupied Bed Making".
5. Projector
6. Pillowcase (bottom of pile)
7. Plastic pillow cover
8. Bedspread
9. Blanket
10. Top sheet
11. Cotton pad or (optional)
12. Cotton draw sheet (optional at some facilities)
13. Plastic or rubber draw sheet (optional at some facilities)
14. Bottom sheet
15. Mattress pad or cover (top of pile)
16. Laundry hamper or bag

5. Place non-skid mat in shower stall if client is standing during shower.

6. Identify and greet client. Identify self.

7. Explain what you are going to do.

8. Offer toileting.

B. Shower procedure

9. Provide privacy and assist client to put on robe and slippers.

10. Ambulate or transfer per shower chair to shower room.

11. Assist client to undress, cover with bath blanket until ready to start shower.

12. Adjust spray temperature (95-105 degrees Fahrenheit). Direct spray away from client while adjusting it. Flow rate should be gentle.

    NOTE: A shampoo may be given at this time.

13. Rinse client's body with warm water.

14. Assist client in washing as needed.

15. If client is unable to help at all, start with eyes, then wash face, ears, neck, chest, abdomen, and back. Rinse with warm water.

    NOTE: Ask if client wants soap used on his/her face.

16. Wash each leg, foot and between toes. Rinse well with warm water; discard washcloth.

17. Wash peri areas from front to back.

    NOTE: Wash female labia area from front of chair; wash anal area from under chair.

18. Wash between buttocks and discard washcloth; rinse well from front to back.

19. Turn off shower and cover client with bath blanket; place around hair if wet.

20. Uncover client, one area at a time, and pat dry.

21. Apply powder, lotion and deodorant, if applicable.

22. Assist with dressing.

C. Steps ending procedure

24-28. See III. C., steps 25-29 of tub bath procedure.

IV. Summary and Conclusion

A. Key points of tub bath

B. Key points of shower

C. Classroom discussion

D. Review steps of procedures.

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. How long does a client usually stay in the tub?
2. What should you do first if a client becomes faint while giving a tub bath?
3. What kind of observations could you make about the client during a tub bath or shower?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Instructor demonstrates tub bath procedure.
3. Students assist with tub bath procedure during supervised clinical experience.
4. Instructor demonstrates shower procedure.
5. Students assist with shower procedure during supervised clinical experience.

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 1. The client usually stays in the tub for 10-15 minutes; any longer may result in the client becoming cold.

______ 2. Always add bath oil to the bathtub water to moisturize the skin.

______ 3. The bathroom door should never be locked when a client is taking a tub bath alone.

______ 4. The shower nozzle should rest on the floor when not in use.

______ 5. Always check shower chair wheels prior to using for sticking or wobbling and a properly functioning locking system.

______ 6. If a client becomes faint while giving a tub bath or shower, first call for help and then take the appropriate actions.

______ 7. What is the order in which you should bathe the client's body if giving a shower to a totally helpless individual?

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. T
2. F
3. T
4. F
5. T
6. T
7. Bathe in this order: eyes, face, ears, arms, hands, chest, abdomen, back, legs, feet, between toes, peri area.

DID THE STUDENT	YES	NO
9. Explain procedure to client.		
10. Offer toileting.		
B. Tub bath procedure		
11. Provide privacy and assist client to put on robe and slippers.		
12. Ambulate or transfer w/c or g/c to tub room.		
13. Fill tub with 105 Degrees Fahrenheit water half full and check water temperature with bath thermometer.		
14. Assist client to undress.		
15. Assist client into the tub.		
16. Assist client as needed in washing.		
17. If client is unable to help, start with eyes, then wash face, then wash face, ears, neck, arms, hands, chest, abdomen, and back. Rinse with warm water.		
18. Wash each leg, foot, and between toes. Rinse well warm water; discard washcloth.		
19. Wash peri area from front to back and discard washcloth.		
20. Drain tub and remove soap before client gets out.		
21. Assist client out of the tub, cover with a bath blanket and assist to chair.		
22. Uncover client, on area at a time, and pat dry with a towel.		

DID THE STUDENT	YES	NO
Shower Procedure		
9. Provide privacy and assist client to put on robe and slippers or cover with bath blanket.		
10. Ambulate or transfer per shower chair to shower room.		
11. Assist client to undress; cover with bath blanket until ready to start shower.		
12. Adjust spray temperature (95-105 degrees Fahrenheit). Direct spray away from client while adjust it. Flow rate should be gentle.		
13. Rinse client's body with warm water.		
14. Assist client in washing as needed.		
15. If client is unable to help at all, wash client in correct sequence.		
16. Wash each leg, foot and between toes. Rinse well with warm water; discard washcloth.		
17. Wash peri area from front to back		
18. Wash between buttocks and discard washcloth; rinse well from front to back.		
19. Turn off shower and cover client with bath blanket; place around hair if wet.		

DID THE CLIENT	YES	NO
20. Uncover client, one area at a time, and pat dry.		
21. Apply powder, lotion and deodorant, if applicable.		
22. Assist with dressing.		
C. Steps ending procedure		
23-27. Complete steps 25-29 of bath procedure.		

The student has satisfactorily completed the procedure "TUB BATH AND SHOWER BATH" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

TEACHER RESOURCES:

INTRODUCTION:

A comfortable, clean and neatly made bed is extremely important to the elderly. A clean, wrinkle-free bed is especially important for the client on bed rest. This is a simple nursing measure the nurse assistant can take to prevent skin breakdown which can lead to decubitis ulcers. In addition, making a bed using the following procedure will make the room appear neat which is important to the client's feelings about his/her home. Procedures may vary slightly in facilities depending on type of linen used.

LESSON PLAN: 34

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for Tub Bath

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. See that tub/shower room is free from drafts, preferably 75-80 degrees Fahrenheit.
4. Clean bathtub/shower chair with disinfectant solution and rinse well.
5. Place non-skid mat, towel, or tub chair in bathtub.
7. Place a chair next to tub.
8. Identify and greet client. Identify self.
9. Explain what you are going to do.
10. Offer toileting.

B. Tub bath procedure

11. Provide privacy and assist client to put on robe and slippers.
12. Ambulate or transfer per w/c or g/c to tub room.
13. Fill tub with 105 degree Fahrenheit water half full and check water temperature with bath thermometer.
14. Assist client to undress.
15. Assist client into the tub.

NOTE: A shampoo may be given at this time.

16. Assist client as needed in washing.

NOTE: Offer assistance to wash back, legs and feet.

17. If client is unable to help, start with eyes, then wash face, ears, neck, arms, hands, chest, abdomen, and back. Rinse with warm water.

    NOTE: Ask if client wants soap used on his/her face.

18. Wash each leg, foot, and between toes. Rinse well with warm water; discard washcloth.

19. Wash peri area from front to back and discard washcloth.

    NOTE: Ask or assist client to turn slightly to one side.

20. Drain tub and remove soap before client gets out.

21. Assist client out of tub; cover with a bath blanket and assist to the chair.

22. Uncover client, one area at a time, and pat dry with towel.

23. Apply powder, lotion and deodorant, if applicable.

24. Assist with dressing.

C. Steps ending procedure

25. Return client to his/her room; assist with any personal care such as shaving, nail care, hair care, etc.

26. Make client comfortable; place call signal with in reach.

27. Return to tub room, remove soiled articles and clean tub with disinfectant solution.

28. Wash your hands.

29. Record observations.

    NOTE: Report anything unusual to charge nurse.

IV. Steps of Procedure for a Shower Bath

A. Steps beginning procedure

1-4. See III. A., steps 1-4 of tub bath procedure.

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ______________________

BEDMAKING (UNOCCUPIED/OCCUPIED)

EQUIPMENT:

1. Pillowcase
2. Plastic pillow cover
3. Bedspread
4. Blanket
5. Top sheet
6. Cotton pad or (optional)
5. Bath blanket
6. Soap and soap dish
7. Powder (optional)
7. Cotton draw sheet
8. Plastic or rubber draw sheet
9. Bottom sheet
10. Mattress pad or cover
11. Laundry hamper or bag

DID THE STUDENT	YES	NO
Making an Unoccupied Bed		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary linens in order to be used.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
B. Unoccupied bedmaking procedure		
5. Raise bed to high position; lower bed rails.		
6. Remove pillow, strip pillowcase.		
7. Strip bed, place soiled linen in hamper or bag.		
8. Wash and dry mattress if soiled.		
9. Place mattress pad on bed and pull smooth.		

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Bedmaking

A. An unoccupied bed is made up when the bed is not being used.

B. An occupied bed is made up with the client in it; it is usually part of the complete/partial bed bath.

C. Linen should be changed as often as needed to assure cleanliness.

D. Make one side of the bed at a time and then finish the other side to save time and energy.

E. Remove soiled linens without shaking or coming in contact with the nurse assistant's face or uniform.

NOTE: Linens are covered with the client's germs.

F. Place soiled linens in the proper receptacle--never on the floor or bedside table or another client's unit.

G. Check linen for dentures, jewelry, plastic, glass, chux, face tissue, or anything else before stripping the bed.

15. Place top sheet, halved, full length of bed, with hem at edge of head end of mattress.

    NOTE: Always place linen over footboards or cradles. These devices are used to protect toes and feet from pressure.

16. Unfold the top sheet and place it level with the top edge of the head of the mattress.

17. Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.

18. Place bedspread (centered) over top sheet and blanket, leave enough spread to cover a pillow at top edge.

19. Miter lower corner of sheet, blanket, and spread together on near side; allow to hang free.

20. Gather open end of pillowcase in one hand, full length, and grasp pillow edge with same hand; with free hand fit pillow corners into case. (HO 2).

21. Place pillow on near half of bed with open end of case away from the doorway; walk to far side of bed.

22. Fold back on bed each piece of linen.

23. Pull mattress pad smooth and tuck under mattress from head to foot.

24. Pull bottom sheet tight; tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.

25. Tighten plastic draw sheet; tuck in middle first, then top 1/3, and finally bottom 1/3.

26. Repeat step 25 with cotton draw sheet.

27. Pull top sheet blanket and bedspread straight; tuck under foot end of mattress.

28. Miter corner with sheet, blanket, and spread.

29. Place pillow in center of head of bed; pull bedspread over.

C. Steps ending procedure

30. Lower bed and recess bed cranks.

31. Raise bed rail on opposite side of entry.

IV. Steps of Procedure for Making an Occupied Bed

A. Steps beginning procedure

1-4. See steps 1-4 of procedure for making an unoccupied bed.

B. Occupied bedmaking procedure

5. Provide privacy.

6. Raise bed to comfortable working position, side rails up unless you are working on that side.

7. Lower back and knee rest until bed is flat, if client's condition allows.

8. Loosen the top of bedding at foot of bed.

9. Remove spread; fold spread to foot of bed; remove by grasping center; place on back of chair.

10. Remove blanket according to above procedure.

11. Place bath blanket over top sheet. Ask client to hold blanket in place or tuck under client's shoulders. Remove top sheet and place in laundry hamper or bag.

12. Keep pillow under client's head and turn client to side of bed you are not making.

13. Loosen bottom bedding; free bottom linen and roll each piece separately to the client's back.

14. Place mattress pad on bed lengthwise with fold in the center.

15. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.

16. Tuck sheet under head of mattress, miter corners; tuck well under side of mattress.

17. Fanfold surplus sheet close to client's back.

18. Place rubber/plastic draw sheet on middle 1/3 of mattress; fanfold 1/2 to client's back and tuck in near side only.

19. Center draw sheet; fanfold half to client's back; tuck other end under mattress.

20. Raise bed side rail; assist client in turning and moving to clean side of bed.

21. Move and keep pillow under client's head.

22. Go to opposite side of bed; lower bed side rail.

23. Pull through all bottom linen; remove and discard soiled linen in laundry hamper or bag.

24. Pull clean mattress pad toward edge of bed - tuck under mattress.

25. Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner.

26. Pull the sheet toward foot of bed and tuck under mattress.

27. Pull rubber or plastic sheet and cotton draw sheet; tighten; and tuck under the mattress.

28. Assist client to center of bed.

29. Place top sheet over bath blanket; ask client to hold or tuck under client's shoulders.

30. Remove bath blanket.

31. If blanket is used, place over top sheet; place bedspread over blanket even with top sheet.

32. Make tuck in top linen at food of bed.

NOTE: Make toe pleat by folding over two (2) inches where feet are. (HO-1)

33. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side.

34. Change pillowcase and place under client's head. (HO-2)

C. Steps ending procedure

35. Lower bed and recess bed cranks.
36. Both side rails should be up.
37. Place call signal within reach.
38. Take dirty linen to laundry room.
39. Wash your hands

IV. Summary and Conclusion

A. Key points of bedmaking.
B. Classroom discussion.
C. Review steps of procedures.

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. Why is linen stacked in the order of use?
2. Why should soiled linen be removed without shaking or coming in contact with the nurse assistant's face or uniform?
3. When using a footboard, how would you place the top sheet, blanket, and spread?
4. Why is it important to complete as much as possible on one side of the bed before doing to the other side?
5. What is the significance of a clean, wrinkle-free bed for the client?
6. How often do you change the bed linen of the incontinent client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Instructor demonstrates unoccupied bedmaking procedure.
3. Students practice unoccupied bedmaking procedure.
4. Instructor demonstrates occupied bedmaking procedure.
5. Students practice occupied bedmaking procedure.

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. Describe the difference between an unoccupied and occupied bed.

2. Soiled linens should be placed: Circle the letter of the correct answer.)

   a. On the floor
   b. In the clothes hamper/bag
   c. On the bedside table
   d. On the chair

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 3. By making one side of the bed and then going over to the other side and finishing it, you will save time and energy.

______ 4. Linen should be changed once a week.

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. An unoccupied bed is one that is not being used. An occupied bed has the client in it.
2. b
3. T
4. F

DID THE STUDENT	YES	NO
10. Unfold bottom sheet on bed, full length, with bottom hem at bottom edge of mattress.		
11. Tuck in head end of bottom sheet and miter corner.		
12. Tuck in near edge of bottom sheet, working from head to foot.		
13. Folding plastic draw sheet in half, place on middle 1/3 of mattress; tuck in near side only.		
14. Folding cotton draw sheet in half, place over plastic draw sheet and tuck near side only.		
15. Place top sheet, halved, full length of bed, with hem at edge of the head of the mattress.		
16. Unfold the top sheet and place it level with the top edge of the head of the mattress.		
17. Place blanket over top sheet centered on bed and about eight (8) inches down from the edge of the top sheet.		
18. Place bedspread (centered) over top sheet and blanket; leave enough spread to cover a pillow at top edge.		
19. Miter lower corner of sheet, blanket, and spread together on near side; allow to hand free.		
20. Gather open end of pillowcase in one hand, full length, and grasp pillow edge with same hand; with free hand fit pillow corners into case.		
21. Place pillow on near half of bed with open end of case away from the doorway; walk to far side of bed.		
22. Fold back on bed each piece of linen away from the doorway; walk to far side of bed.		

DID THE STUDENT	YES	NO
23. Pull mattress pad smooth and tuck under mattress from head to foot.		
24. Pull bottom sheet tight; tuck under head of mattress; miter corner; tuck in remainder of sheet from head to foot.		
25. Tighten plastic draw sheet; tuck in middle first, then then top 1/3, and finally bottom 1/3.		
26. Repeat step 25 with cotton draw sheet.		
27. Pull top sheet, blanket, and bedspread straight; tuck under foot end of mattress.		
28. Miter corner with sheet, blanket, and spread.		
29. Place pillow in center of head of bed; pull bedspread over.		
C. Steps ending procedure 30. Lower bed and recess bed cranks.		
31. Raise bed rail on opposite side of entry.		
Making an Occupied Bed A. Steps beginning procedure 1-4. Complete steps 1-4 of unoccupied bedmaking procedure.		
5. Provide privacy.		
6. Raise bed to comfortable working position; side rails up (unless he/she is working on that side.)		
7. Lower back and knee rest until bed is flat, if client's condition allows.		

DID THE STUDENT	YES	NO
8. Loosen the top of bedding at foot of bed.		
9. Remove spread; fold spread to foot of bed; remove by grasping center; place on back of chair.		
10. Remove blanket according to above procedure.		
11. Place bath blanket over top sheet. Ask client to hold blanket in place or tuck under client's shoulders. Remove top sheet and place in laundry hamper of bag.		
12. Keep pillow under client's head and turn client to side of bed he/she is not making.		
13. Loosen bottom bedding; free bottom linen and roll each piece of linen separately to the client's back.		
14. Place mattress pad on bed lengthwise with fold in center.		
15. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress.		
16. Tuck sheet under head of mattress; miter corners; tuck well under side of mattress.		
17. Fanfold surplus sheet close to client's back.		
18. Place rubber/plastic draw sheet on middle 1/3 of mattress; fanfold 1/2 to client's back and tuck in near side only.		
19. Center draw sheet; fanfold half to client's back; tuck other end under mattress.		
20. Raise bed side rail; assist client in turning and moving to clean side of bed.		

LESSON PLAN: 35

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for Making an Unoccupied Bed

A. Steps beginning procedure

1. Wash your hands.
2. Arrange necessary linens in order to be used.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.

B. Unoccupied bedmaking procedure

5. Raise head to high position; lower bed rails.

   NOTE: Bed should be in flat position.

6. Remove pillow, strip pillowcase.
7. Strip bed, place soiled linen in hamper or bag.
8. Wash and dry mattress, if soiled.
9. Place mattress pad on bed and pull smooth.
10. Unfold bottom sheet on bed, full length, with bottom hem at bottom edge of mattress.

NOTE: For fitted sheets, tuck in both sides of mattress pad and make sure all four corners are fitted securely under the corners.

11. Tuck in head end of bottom sheet and miter corner. (HO-1)
12. Tuck in near edge of bottom sheet, working from head to foot.
13. Folding plastic draw sheet in half, place on middle 1/3 of mattress; tuck in near side only.
14. Folding cotton draw sheet in half, place over plastic draw sheet and tuck in near side only.

DID THE STUDENT	YES	NO
21. Move and keep pillow under client's head.		
22. Go to opposite side of bed; lower bed side rail.		
23. Pull through all bottom linen; remove and discard soiled lined in laundry hamper or bag.		
24. Pull clean mattress pad toward edge of bed; tuck under mattress.		
25. Pull clean bottom sheet toward the edge of bed, Tuck it under the mattress at the head of the bed and make a mitered corner.		
26. Pull the sheet toward foot of bed and tuck under mattress.		
27. Pull rubber or plastic sheet and cotton draw sheet; tighten; and tuck under the mattress.		
28. Assist client to center of bed.		
29. Place top sheet over bath blanket; ask resident to hold or tuck under clients shoulders.		
30. Remove bath blanket.		
31. If blanket is used, place over top sheet; place bedspread over blanket even with top sheet.		
32. Make tuck in top linen at foot of bed.		
33. Tuck sheet, blanket, and bedspread to foot of bed under mattress and miter corners on each side.		
34. Change pillowcase and place under client's head.		

DID THE STUDENT			
C. Steps ending procedure			
35. Lower bed and recess bed cranks, if not an electric bed.			
36. Both side rails should be up.			
37. Place call signal within reach.			
38. Take dirty linen to laundry room.			
39. Wash hands.			

The student has satisfactorily completed the procedure "BEDMAKING (UNOCCUPIED/OCCUPIED)" according to the steps outlined.

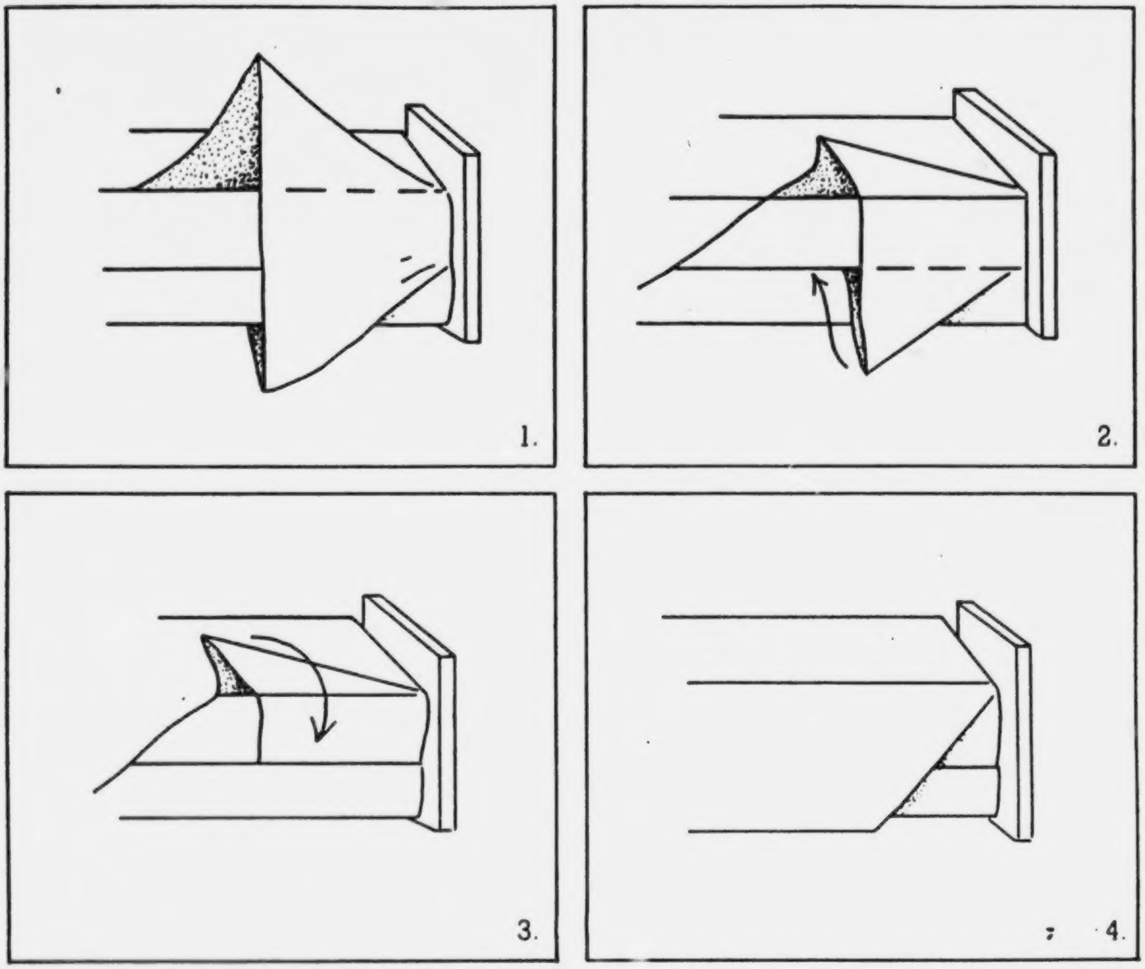
____
Instructor's signature
(Verifying Satisfactory Completion)

____
Date

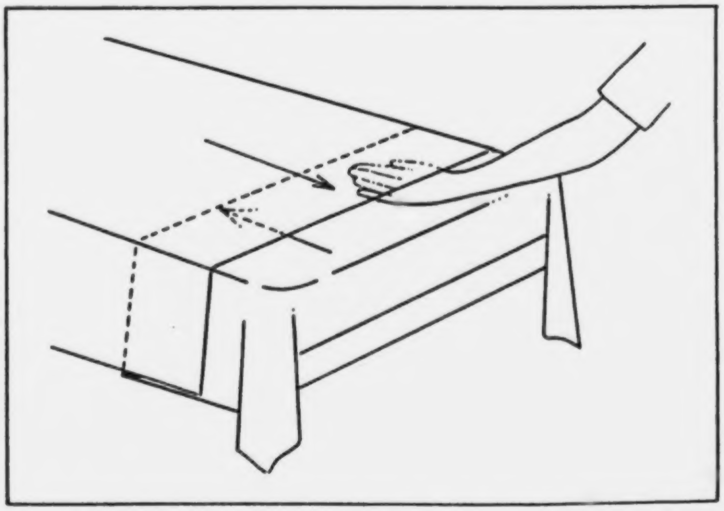
MAKING A MITERED CORNER & TOE PLEAT

HO 1

Mitered Corner

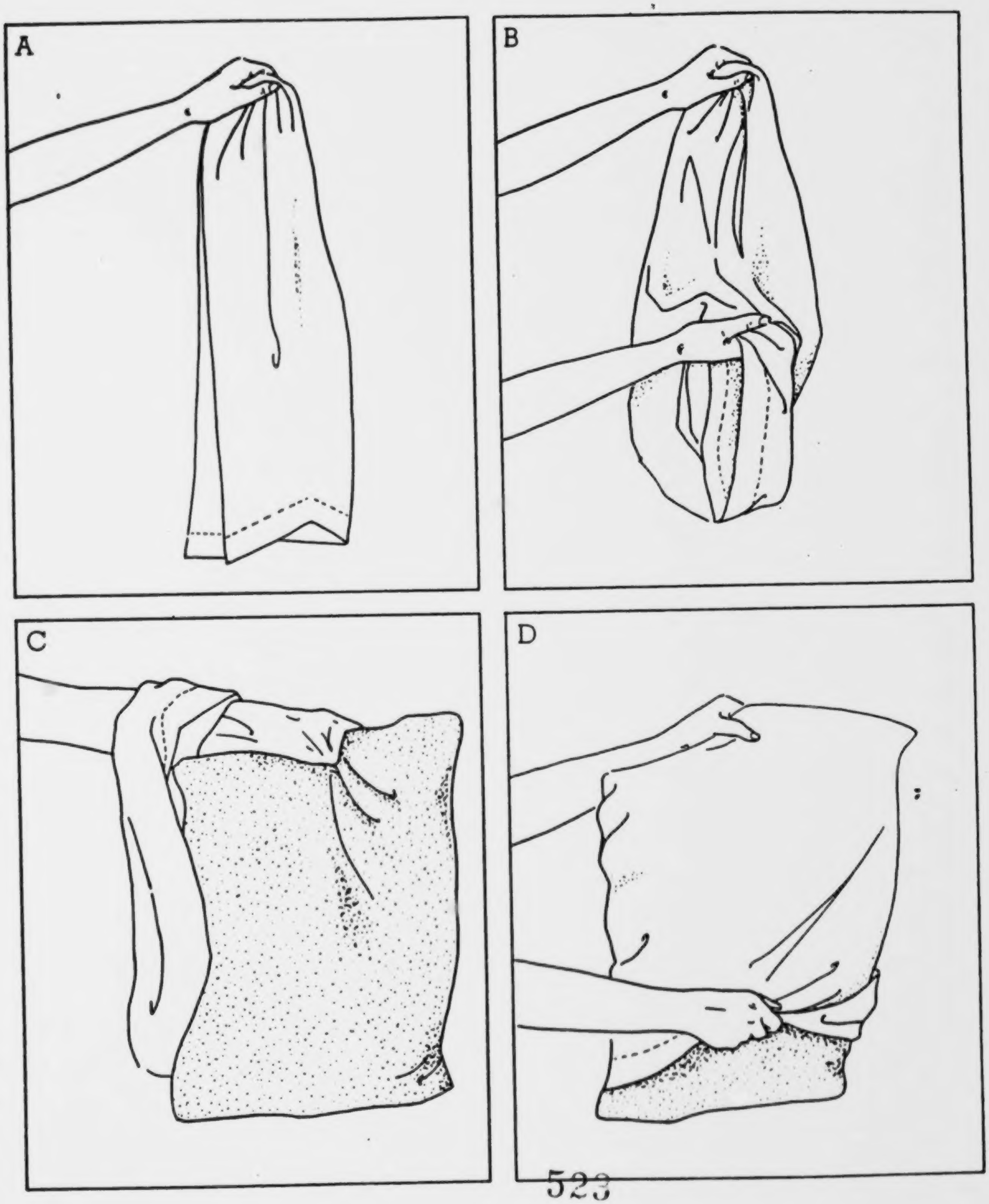


Toe Pleat



PUTTING ON THE PILLOW CASE

HO 2



LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-36 OR DEMONSTRATION: VI-36

ORAL HYGIENE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. List four purposes of oral hygiene.
3. List three observations the nurse assistant can make while giving oral hygiene.
4. Recognize four key points in the care of dentures.
5. Demonstrate assisting with oral hygiene according to the steps of procedure.
6. Demonstrate administering oral hygiene to the helpless or unconscious client according to the steps of procedure.
7. Demonstrate how to provide denture care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #269: "Oral Hygiene"
2. Projector
3. Cup or glass
4. Emesis basin
5. Water
6. Toothbrush
7. Hand towel
8. Toothpaste, powder, or denture cleanser
9. Mouthwash
10. Denture cup (if applicable)
11. Clean washcloth, towel
12. Tongue depressor
13. Lemon and glycerine swab, toothette, or other mouth care swab
14. Lip balm

TEACHER RESOURCES:

INTRODUCTION:

Oral hygiene is the cleaning and care of the teeth, gums, and inside surfaces of the mouth. Plaque is a sticky, transparent bacterial film found on the teeth. If plaque is not removed, it will react with sugar from foods eaten to produce an acid and toxins which can dissolve the outer covering of the teeth causing decay and irritation of gums. Eventually it can lead to loss of teeth. Good brushing and mouth care can remove the plaque.

Think about how your mouth tastes upon waking up in the morning or by the end of the day. It can definitely affect your appetite and the way you feel. Halitosis can prevent communication from occurring; it is uncomfortable to be around someone who has "bad breath."

Many of the clients cannot carry out this procedure by themselves; others may only need for you to prepare everything for them. See that clients get proper mouth care.

LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Terms and Definitions

A. Halitosis - bad breath

B. Plaque - sticky, transparent bacterial film found on the teeth (CD-1)

II. Key points of Oral Hygiene

A. A clean mouth and properly functioning teeth are essential for physical and mental well-being of the client.

B. Purposes of oral hygiene (mouth care)

1. Prevent infections in mouth.

2. Remove food particles and plaque

3. Stimulate circulation of gums

4. Eliminate bad taste in mouth, thus food is more appetizing

C. A client should have oral hygiene at the following times:

1. After meals and at h.s.

2. The unconscious client requires mouth care q 2 hours.

a. He/she usually breathes only through the mouth causing secretions to stick on surfaces of the mouth.

b. Always keep the head turned to the side to allow for secretions to drain from the mouth and preventing them from collecting at the back of his/her throat which could result in choking. (CD-5)

D. Specific observations to make

1. Tooth decay (blackened), any loose or broken teeth

2. Red or swollen gums

3. Sores or white patches in the mouth or on the tongue

4. Changes in eating habits

   NOTE: If client avoids foods that require a lot of chewing it may indicate pain in mouth.

5. Ill-fitting dentures

E. All mouth-care equipment (toothbrush, cup, toothpaste) of the client should be labeled with his/her name to prevent mixing up equipment. This could be a source of spreading infection.

F. Dilute mouthwash since it has such a strong flavor: 1/2 part mouthwash to 1/2 part water. (CD-4)

G. Mouthwash does not replace the need to brush teeth; it only makes the mouth taste fresher.

III. Key Points of Denture Care

A. Handle dentures (false teeth) carefully to prevent damage; they are expensive to replace. (CD-6)

B. Keep dentures in water when not in the mouth to prevent warping; never use hot water to clean or store them, it could also cause warping.

C. Soaking dentures in denture solution does not eliminate the need for daily brushing.

D. Denture cup should be labeled with client's name.

IV. Steps of Procedure to Assist With Oral Hygiene

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment for client.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Wear disposable gloves if assisting client with procedure.
6. Provide privacy.

B. Assist with oral hygiene procedure

7. Dilute mouthwash (1/2 mouthwash to 1/2 water).
8. Assist client to bathroom or upright sitting position.
9. Pour water over toothbrush; instruct or assist client to put a small amount of toothpaste on the toothbrush.
10. Instruct or assist client to brush along gumline, then brush teeth up and down on both sides.
11. Brush the biting surfaces of the molars with a back and forth motion.
12. Brush the tongue gently.
13. Instruct or assist client to rinse his/her mouth with water; hold emesis basis under client's chin with one hand.
14. Allow client to spit into emesis basin or sink; wipe lips with towel.
15. Provide client with mouthwash (may use a straw); instruct client to swish around in mouth and spit out.

    NOTE: Instruct client not to swallow mouthwash.

16. Allow client to spit into emisis basin or sink; wipe lips with towel.

17. Lubricate lips with lip balm (CD-3)

C. Steps ending procedure

18. Remove, clean, and store equipment.

19. Wash hands; wash client's hands.

20. Make client comfortable.

21. Record observations.

NOTE: Report anything unusual to charge nurse.

V. Steps of Procedure for Oral Hygiene for Helpless or Unconscious Client

A. Steps beginning procedure

1-6. See steps 1-6 of assist with oral hygiene procedure.

B. Oral hygiene for helpless client procedure.

7. Move the client to the side of the bed nearest you.

8. Spread towel under client's chin.

9. Moisten wash cloth over the emesis basin with diluted mouthwash.

10. Client without teeth: Wrap the wet cloth securely around a tongue depressor to clean the tongue and inside surfaces of mouth.

Client with teeth: Wrap the wet cloth securely around a tongue depressor to clean the tongue and inside surface of mouth.

11. Moisten toothbrush with diluted mouthwash. Brush gumline and teeth in up-and-down motion on both sides.

12. Wipe lips with a towel.

13. Apply lip balm to the client's lips.

C. Steps ending procedure

14-17. See steps 18-21 of assist with oral hygiene procedur .

VI. Steps of Procedure for Denture Care

A. Steps beginning procedure

1-6. See steps 1-6 of assist with oral hygiene procedure.

B. Denture care procedure

7. Ask the client to remove dentures or run your fingers along the top of the upper gum as you gently push the upper edge of the denture forward and down. Lower dentures can be removed the same way along the lower gumline; push forward and up.

8. Place dentures in clean denture cup.

9. Provide water or diluted mouthwash to rinse the mouth of food particles.

10. Allow client to spit into emesis basin or sink.

11. Have client wipe mouth with towel or tissue.

12. Apply lip balm to lubricate lips.

13. Fill a clean sink 1/2 full of cool water or place a clean washcloth on bottom of sink.

14. Brush dentures thoroughly using toothbrush and denture cleanser.

15. Rinse dentures with cool water and place in a clean cup.

16. If client wants to wear dentures, replace them in mouth (upper plate first).

17. If client is not going to wear dentures, store in a clean denture cup filled with appropriate solution.

C. Steps ending procedure

18-21. See steps 18-21 of assist with oral hygiene procedure.

VII. Summary and Conclusion

A. Terms and definitions

B. Key points of oral hygiene

C. Key points of denture care

D. Classroom discussion

E. Review steps of procedures.

LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. What is plaque?
2. If plaque is not removed, what will happen?
3. What is the purpose of lip balm?
4. What can you do to make mouthwash more acceptable to the client?
5. Why do you not give the unconscious client mouthwash to rinse his/her mouth with?
6. What can the nurse assistant do to protect the client's dentures from breakage when cleaning them?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrips.
2. Instructor demonstrates assisting with oral hygiene.
3. Students practice assisting with oral hygiene. Have students brush each other's teeth.
4. Instructor demonstrates providing oral hygiene to the helpless client.
5. Students practice giving oral hygiene to the helpless client.
6. Instructor demonstrates giving denture care.
7. Students practice giving denture care.

LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. Define the term halitosis.

2. What is plaque?

3. List the four purposes or oral hygiene.

   a.

   b.

   c.

   d.

4. List three observations the nurse assistant can make while giving oral hygiene.

   a.

   b.

   c

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 5. Oral hygiene should only be done at h.s.

______ 6. The unconscious client needs mouth care every 2 hours.

______ 7. Dentures should be cleaned over a sink half full of water or with a clean washcloth on the bottom.

______ 8. Dentures cannot become warped.

______ 9. It is not necessary to brush the dentures if they have been soaking in a cleaning solution overnight.

______ 10. It is very important that the denture cup is labeled with the owner's name so they can be identified.

LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. Halitosis - bad breath
2. Plaque - sticky, transparent bacterial film found on the teeth
3. a. Prevent infection in the mouth
   b. Remove food particles and plaque
   c. Stimulate circulation of gums
   d. Eliminate bad taste in mouth
4. The student may list any three of the following:
   a. Tooth decay (blackened), and loose or broken teeth
   b. Red or swollen gums
   c. Sores or white patches in the mouth or on the tongue
   d. Changes in eating habits
   e. Ill-fitting dentures
5. F
6. T
7. T
8. F
9. F
10. T

LESSON PLAN: 36

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

ORAL HYGIENE

EQUIPMENT:

1. Cup or glass
2. Emesis basin
3. Water
4. Toothbrush
5. Hand towel
6. Toothpaste, powder, or denture cleanser
7. Mouthwash

DID THE STUDENT	YES	NO
Assist with Oral Hygiene		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment for client.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Wear disposable gloves.		
6. Provide privacy.		
B. Assist with oral procedure		
7. Dilute mouthwash (1/2 mouthwash to 1/2 water).		
8. Assist client to bathroom or upright sitting position.		
9. Pour water over toothbrush; instruct or assist client amount of toothpaste on the toothbrush.		

DID THE STUDENT	YES	NO
10. Instruct or assist client to brush along gumline, then brush teeth up and down on both sides.		
11. Brush the biting surfaces of the molars with back-and-forth motion.		
12. Brush the tongue gently.		
13. Instruct or assist client to rinse his/her mouth with water; hold emesis basin under client's chin with one hand.		
14. Allow client to spit into emesis basin or sink; wipe lips with towel.		
15. Provide client mouthwash (may use a straw); instruct client to swish around in mouth and spit out, cautioning client not to swallow.		
16. Allow client to spit into emesis basin or sink; wipe lips with hand towel.		
17. Lubricate lips with lip balm.		
C. Steps ending procedure		
18. Remove, clean, and store equipment.		
19. Wash hands, wash client's hands.		
20. Make client comfortable.		
21. Record observations, reporting anything unusual to charge nurse.		

DID THE STUDENT	YES	NO
Oral Hygiene for Helpless or unconscious Client		
A. Steps beginning procedure		
1-6. Complete steps 1-6 of assist with oral hygiene procedure.		
B. Oral Hygiene for helpless client procedure.		
7. Move the client to the side of the bed toward him/her.		
8. Spread towel under client's chin.		
9. Moisten wash cloth over the emesis basin with diluted mouthwash.		
10. Client without teeth: Wrap the wet cloth around his/her fingers and clean the tongue and inside surfaces of mouth.		
11. Moisten toothbrush with diluted mouthwash. Brush gumline and teeth in up-and down motion on both sides.		
12. Wipe lips with a towel.		
13. Apply lips balm to the client's lips.		
Denture Care		
A. Steps beginning procedure		
1-6. Complete steps 1 through 5 of assist with oral hygiene procedure.		
B. Steps beginning procedure		
7. Ask the client to remove dentures or remove client's dentures.		
8. Place dentures in clean denture cup.		

DID THE STUDENT	YES	NO
9. Provide water or diluted mouthwash to rinse the mouth of food particles.		
10. Allow client to spit into emesis basis or sink.		
11. Have client wipe mouth with towel or tissue.		
12. Apply lip balm to lubricate lips.		
13. Fill a clean sink 1/2 full of cool water or place a clean washcloth on bottom sink.		
14. Brush dentures thoroughly using toothbrush and denture cleanser.		
15. Rinse dentures with cool water and place in a clean cup.		
16. If client wants to wear dentures, replace them in mouth.		
17. If client is not going to wear dentures, store in a clean denture cup filled with appropriate solution.		
C. Steps ending procedure 18-21. Complete steps 18-21 of assist with oral hygiene procedure.		

The student has satisfactorily completed the procedure "ORAL HYGIENE" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-37 OR DEMONSTRATION: VI-37

SHAVING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Recognize three key points related to shaving.
2. Demonstrate how to shave a client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Shaving the Client
2. Basin/sink of hot water
3. Razor (safety or electric)
4. Mirror
5. Shaving cream
6. Washcloth
7. Pre-shave lotion (electric)
8. After-shave lotion

TEACHER RESOURCES:

INTRODUCTION:

A clean-shaven face is necessary for the male client to feel and appear neat and well-kept in his appearance. Some men need to be shaved daily; others need it less often.

As the female client grows older, she also may have excessive facial hair. This can be embarrassing. Many females do shave and should be offered assistance when needed.

The equipment used depends upon what is in the client's home or at the facility. The following procedures discuss the use of either a safety or electric razor. This may be a very new experience for you, take your time and follow the steps in the procedure.

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Shaving

A. Perform shaving procedure in the client's bedroom or bathroom, not in a public area.

B. Soften the beard with a warm, wet washcloth.

C. Always apply lather or shaving cream before shaving with a safety razor. This also helps to soften the beard and prevents irritating the skin.

D. For a comfortable and easy shave, remember to shave in the direction that hair grows; downward over the cheeks and chin; upward over the neck area.

E. Apply an antiseptic, such as alcohol, if the skin is nicked or apply pressure using a clean cloth for a minute or so until oozing stops.

F. Electrical appliances should not be used in the bathroom.

G. Use the client's own razor; if using the facility's electric razor, clean the part that comes in contact with the skin with alcohol before and after using.

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

II. Steps of Procedure for Safety Razor Method

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet **client** Identify self.
4. Explain what you are going to do.
5. Provide privacy.

B. Safety razor procedure

6. Position client in chair or sitting position in bed in well-lit area.
7. Spread towel under client's chin.
8. Wet face with warm water.
9. Apply shaving cream 1/8" thick to face. (CD-1)
10. Leave lather in place about 15-30 seconds. (CD-2)
11. Start stroking downward with razor under sideburns and work downward over the cheek. (CD-3)
12. Continue over the chin. Work upward on neck under the chin. Use short, firm strokes.
13. Rinse the razor often in hot water.
14. Shave area around lips carefully.

    NOTE: You may need to stretch skin gently to shave in creases and sensitive areas. (CD-4)

15. When finished shaving, wash the face of any excess soap or lather.
16. Pat face dry with a towel.
17. Apply after-shave lotion in the client requests it or if it is part of his usual routine.

C. Steps ending procedure:

18. Place call signal within reach, if needed.

19. Remove, clean, and store equipment.

20. Wash your hands.

21. Record observations.
NOTE: Report anything unusual to charge nurse.

III. Steps of Procedure for Electric Razor Method

A. Steps beginning procedure

1-5. See steps 1-5 of Procedure for Safety Razor Method.

B. Shaving with an electric razor (CD-5)

6. Sanitize razor head.

7. Position client in chair or sitting position in bed in well-lit area.

8. Spread towel under client's chin.

9. Wash face thoroughly with soap and water to remove dirt and oil.

10. Apply pre-shave lotion, if client requests it, or if it is part of his usual routine.

11. Start shaving from sideburns holding skin tight and using circular motion, shave neck and around mouth. (CD-6)

12. When finished, apply after-shave lotion if client requests it or if it is part of his usual routine.

13. Sanitize razor head.

C. Steps ending procedure

14-17. See steps 18-21 of procedure for safety razor method.

IV. Summary and Conclusion

A. Key points of shaving

B. Classroom discussion

C. Review steps of procedures.

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. How thickly do you apply the shaving cream or lather?
2. How long should the lather be left on before shaving?
3. What type of stroking motion do you use when shaving with a safety razor?
4. What can you do to make it easier to shave around the mouth area?
5. What is the first step when shaving with an electric razor?
6. What type of motion is used when shaving with an electric razor?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates shaving procedure using a safety razor.
2. Students practice shaving with a safety razor.
3. Instructor demonstrates shaving with a safety razor.
4. Students practice shaving using an electric razor.

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

Multiple Choice:

1. Shaving should be performed in the: (Circle the letter of the correct answer.)

   a. Nurses' station
   b. The activities room
   c. The client's bedroom/bathroom
   d. The hallway

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 2. Shave in the direction that hair grows, upward on the cheeks and downward on the neck area.

______ 3. Apply pressure or alcohol if the skin is nicked while shaving.

______ 4. Rinse electric razor head in cool water before and after use to clean it for the next client.

______ 5. If using a safety razor, always apply lather or shaving cream before shaving the client.

LESSON PLAN: 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. c
2. F
3. T
4. F
5. T

LESSON PLAN: _ 37

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ________________

SHAVING

EQUIPMENT:

1. Basin/skin of hot water
2. Razor (safety or electric)
3. Mirror
4. Shaving cream
5. Washcloth
6. Pre-shave lotion
7. After-shave lotion

DID THE STUDENT	YES	NO
Safety Razor Method		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Safety razor procedure		
6. Position client in chair or sitting position in bed in well-lit area.		
7. Spread towel under client's chin.		
8. Wet face with warm water.		

DID THE STUDENT	YES	NO
9. Apply shaving cream 1/8" thick to face.		
10. Leave lather in place about 15-30 seconds.		
11. Start stroking downward with razor under sideburns and work downward over the cheek.		
12. Continue over the chin. Work upward on neck under the chin. Use short, firm strokes.		
13. Rinse the razor often in hot water.		
14. Shave area around lips carefully.		
15. When finished shaving, wash the face of any excess soap or lather.		
16. Pat face dry with a towel.		
17. Apply after-shave lotion if the client requests it or if it is part of his usual routine.		
C. Steps ending procedure		
18. Place call signal within reach, if needed.		
19. Remove, clean and store equipment.		
20. Wash hands.		
21. Record observations and report anything unusual to charge nurse.		
Electric Razor Method		
A. Steps beginning procedure		
1-5. Complete steps 1-5 of procedure for safety razor method.		

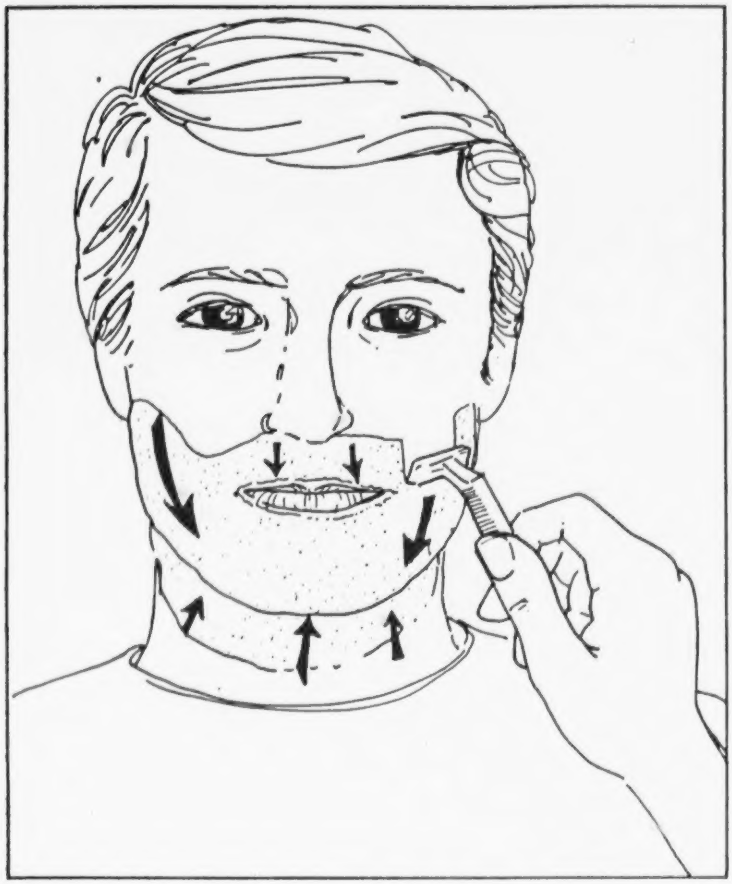
DID THE STUDENT	YES	NO
B. Shaving with an electric razor		
6. Sanitize razor head. method.		
7. Position client in chair or sitting position in bed in well-lit area.		
8. Spread towel under client's chin. well-lit area.		
9. Wash face thoroughly with soap and water to remove dirt and oil.		
10. Apply pre-shave lotion if client requests it, or if it is part of his usual routine.		
11. Start shaving from sideburns holding skin tight and using circular motion, shave neck and around mouth.		
12. When finished, apply after-shave lotion if client requests it, or if it is part of his usual routine.		
13. Sanitize razor head.		
C. Steps ending procedure		
14-17. Complete steps 18-21 of safety razor method procedure.		

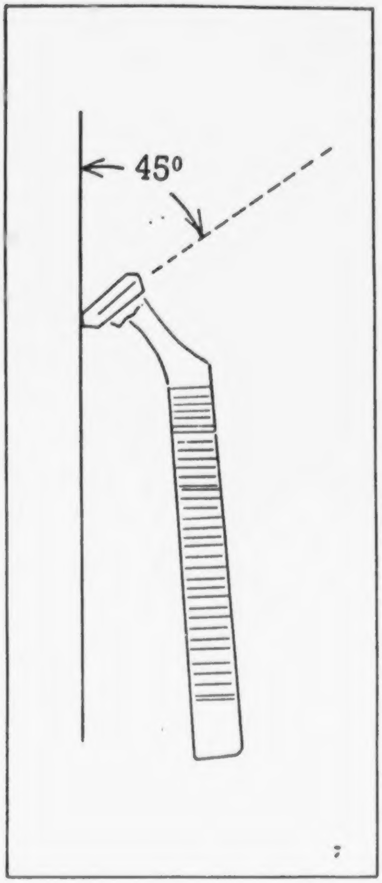
The student has satisfactorily completed the procedure "SHAVING" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

SHAVING THE CLIENT





- Razor should be held at 45° angle to resident's skin.
- Shave in the same direction that the hair grows.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-38 OR DEMONSTRATION: VI-38

BACK RUB/SKIN CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify three purposes of back rub/skin care.
2. List five observations to make while giving a back rub/skin care.
3. Identify four specific measures related to back rub/skin care.
4. Demonstrate how to give a back rub according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Back Rub Methods
2. HO 2: Which Nurse Assistant are You?
3. Lotion
4. Bath towel (with bed bath)
5. Washcloth (with bed bath)
6. Basin with water (with bed bath)
7. Soap and soap dish (with bed bath)

TEACHER RESOURCES:

INTRODUCTION:

Think about how good a back rub feels. We sometimes get so busy feeding, bathing, and toileting our clients that we tell ourselves we don't have time to give a back rub. A back rub is important to our clients and can soothe, calm and comfort them in a special way that no medicine can. A back rub may not seem an important part of your busy day, but to the clients, a back rub means that his/her caregiver really does care.

The bedridden client should have a back rub and skin care to bony areas at the time of each position change. Remember that the skin of the elderly is fragile and easily damaged. A back rub given improperly can cause discomfort, so be gentle. The following procedure describes how to give a good back rub.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Back Rub/Skin Care

   A. Purpose of back rub/skin care

      1. Stimulate circulation
      2. Relax muscles and the client in general
      3. Relieve tension

   B. Specific observations to make

      1. Irritation/redness
      2. Rashes
      3. Bruises
      4. Swelling
      5. Excessive dryness
      6. Sores, lumps or growths
      7. Cuts, abrasions, burns
      8. Mottled skin that is cool to touch

II. Specific Measures Related to Back Rub/Skin Care

   A. Oils or lotions are needed because the skin of the elderly is usually dry and needs the moisturizing effect of lotion.

   B. Warm oils or lotions before applying by placing in pan of warm water or rubbing a small amount in your palms. Apply lotion after bathing a client.

   C. Powder is used to remove skin moisture at skin folds--any area where skin meets skin, under the breasts/large abdomen.

D. Do not shake powder over the client. He/she may inhale tiny powder particles and could develop irritation in the respiratory tract; sprinkle powder in your hand and then apply to the client's skin.

E. The client must be handled with extreme gentleness to prevent bruising and skin tears.

F. The bedridden client must be repositioned every two hours and bony areas massaged gently.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for Giving a Back Rub

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

B. Back rub procedure.

6. Position client on the side of bed closest to you, then turn on his/her side of assist into the prone position.
7. Place bath towel lengthwise close to client's back to protect bedding.
8. Wash, rinse and dry back (if giving a bed bath or if the back is soiled).
9. Warm lotion, then apply to entire back. Begin at the lower back and apply up both sides of spinal column to neck, across shoulders and down to lower back.
10. Massage the buttocks; massage until lotion is absorbed into the skin. Remove the towel.
11. Adjust bed covers and assist client to comfortable position.

C. Steps ending procedure

12. Place call signal within reach, if needed.
13. Remove, clean and store equipment.
14. Wash your hands.
15. Record observations.

NOTE: Report anything unusual to charge nurse.

II. Summary and Conclusion

A. Key points for back rub/skin care

B. Specific measures related to back rub/skin care

C. Classroom discussion

D. Review steps of procedure.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. How do you warm the lotion before applying?
2. In what direction do you massage the client's back?
3. What observations could you make at this time?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates back rub procedure.
2. Students practice back rub procedure.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. Which of the following is not a purpose of giving a back rub/skin care? (Circle the correct answer.)

   a. Increase tension
   b. Relax muscles
   c. Stimulate circulation
   d. Relieve tension

2. List five observations you could make while giving a back rub/skin care.

   a.

   b.

   c.

   d.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 3. Lotion may be warmed before applying it to the skin by rubbing a small amount in the palms of your hands.

_______ 4. Powder is useful for elderly clients since it has a moisturizing effect on the skin.

_______ 5. Shake powder generously to the area that you are applying it to.

_______ 6. The elderly client must be handled gently to prevent skin tears/bruising.

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. a
2. The student may list any five of the following:
   a. Irritation/redness
   b. Rashes
   c. Bruises
   d. Swelling
   e. Excessive dryness
   f. Sores, lumps or growths
   g. Cuts, abrasions, burns
   h. Mottled skin that is cool to touch

3. T
4. F
5. F
6. T

LESSON PLAN: 38

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

BACK RUB

EQUIPMENT:

1. Lotion
2. Bath towel (with bed bath)
3. Washcloth (with bed bath)
4. Basin with water (with bed bath)
5. Soap and soap dish

DID THE STUDENT	YES	NO
Back Rub		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Back rub procedures		
6. Position client on the side of bed closest to him/her, then turn client on side or assist into prone position.		
7. Place bath towel lengthwise close to client's back to protect bedding.		
8. Wash, rinse and dry back (if giving a bed bath or if the back is soiled).		

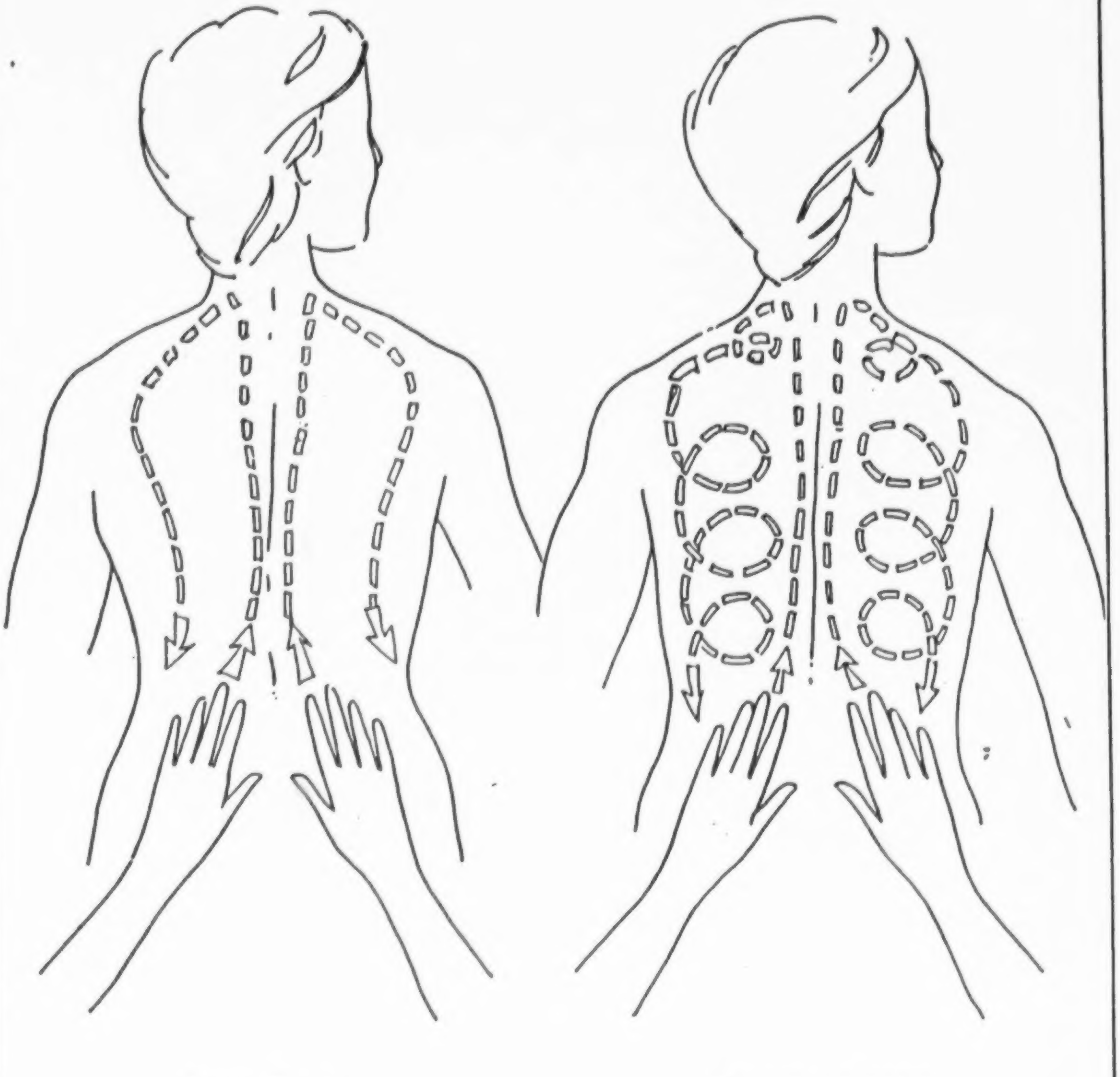
DID THE STUDENT	YES	NO
9. Warm lotion, then apply to entire back. Begin at the lower back and apply up both sides of spinal column to neck, across shoulders and down to lower back.		
10. Massage the buttocks; massage until lotion is absorbed into the skin. Remove the towel.		
11. Adjust bed covers and assist client to comfortable position.		
C. Steps ending procedure		
12. Place call signal within reach, if needed.		
13. Remove, clean and store equipment.		
14. Wash hands.		
15. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "BACK RUB/SKIN CARE" according to the steps outlined.

____
Instructor's signature
(Verifying Satisfactory Completion)

____
Date

BACK RUB METHODS



Long Stroke

Circular Stroke

NURSE ASSISTANT NUMBER ONE

She comes to my room all sad
and forlorn,
Acts like she wishes she had
never been born,
She shrugs her shoulders
And drops her head
As she tiresomely tugs
At the spread,

Then she says very weakly,
"Want a back rub tonight?"
I can't tire her further so
I say, "I'm alright."
Then she pats on my shoulder
And says with a grin
How much she adores me, what a
Good patient I've been.
Then she slides from the room,
Out into the night,
Hoping all of her patients
Will say, "I'm alright."

NURSE ASSISTANT NUMBER TWO

My weary little room
She hits like a breeze,
Smiling and talking and
Wanting to please.
"It's backrub time, Mrs. Smith,
Turn over, let's go."
Then she has me face downward
'Fore I can say no.

Then she tugs at my linens till
They're smooth and neat.
She fluffs up my pillow...
That's always a treat.
Those little uncharted things that
Doctors don't see
Are always remembered by sick
Folks like me.

When I'm healthy
And home again,
You know what I'll do...
I'll always remember
Nurse Assistant Number Two.

Author Unknown

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. What area of the body is cleaned when giving peri care?
2. What position should the client be in during peri care?
3. Where do you start peri care for the male client?
4. Where do you start peri care for the female client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Instructor demonstrates peri care procedure for male client.
3. Students practice peri care procedure for male client.
4. Instructor demonstrates peri care procedure for female client.
5. Students practice peri care procedure for female client.

TEACHER RESOURCES:

INTRODUCTION:

Perineal (abbreviated peri) care is a very important procedure. Many clients will be modest about having someone else clean his/her peri area. Therefore, you should make an effort to respect the client's modesty and still get the area thoroughly cleaned.

Odor is a reliable indicator of whether or not a client is adequately cleaning this area of his/her body. You may need to offer your assistance. The procedure is basically the same for the male and female client, but it will be presented separately since the organs are different for each sex.

If the client has an in-dwelling catheter you should give peri care first, then proceed with catheter care.

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Terms and Definitions

A. Anus - outlet of the rectum

B. Circumcised - surgical removal of the foreskin of the penis

C. Foreskin - loose skin at and covering the end of the penis

D. Labia - the skin folds which are on both sides of the urethra and vagina

E. Perineal - the area between the pubic bone back to and including the anus (CD-1)

F. Scrotum - the pouch containing the testicles

II. Key Points of Peri Care

A. This procedure involves cleaning the area between the pubic bone in front, back to, and including the anus.

B. Purposes of peri care

1. To clean that area for the client who is unable to or has difficulty with adequately cleaning self

2. Prevent skin breakdown of peri area

C. A client should have peri care at the following times:

1. Continent client - daily

2. Incontinent clients - after each voiding or stool

D. Observations to make:

1. Unusual discharge or odors

2. Signs of skin breakdown--redness, irritation

III. Specific Measures Related to Peri Care

A. Wash from front to back to prevent spreading fecal matter from anal area to vagina or urethra (opening to bladder).

B. Offer client bedpan/urinal before starting. Warm water on the peri area may stimulate the need to urinate.

C. For uncircumcised males, retract foreskin and cleanse tip of penis, then return foreskin over tip of penis; if not returned can cause constriction which could lead to tissue damage.

D. Wear disposable gloves through procedure.

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

IV. Steps of Procedure for the Male Client

A. Steps beginning procedure

1. Wash your hands
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Wear disposable gloves.

B. Peri care procedure-male

7. Client should usually lie on his/her back (supine position); place bed protector under buttocks. (CD-2)
8. Cover client with blanket.
9. Expose perineal area. Gently wash the penis starting at the tip (glans) and moving toward body--then rinse.

   NOTE: If client is uncircumcised retract (pull back) the foreskin, wash, rinse and dry then pull the skin over end of penis.
10. Wash and rinse the scrotum.
11. Wash and rinse other skin areas between the legs.
12. Wash and rinse anal area
13. Pat the peri area dry.

C. Steps ending procedure

15. Remove disposable bed protector and bath blanket.
16. Place call signal within reach, if needed.
17. Remove, clean and store equipment.
18. Wash your hands.

19. Make the client comfortable

20. Record observations

    NOTE: Report anything unusual to charge nurse.

V. Steps of Procedure for the Female

A. Steps beginning procedure

1-6. See steps 1-6 of perineal care for the male resident procedure.

B. Peri care procedure-female

7. Assist client to supine or side-lying position; place bed protector under buttocks.

8. Cover client with bath blanket.

9. Expose peri area. Gently wash the inner legs and outer peri area along the outside of the labia.

    NOTE: Use a clean area of washcloth for each swipe.

10. Wash the outer skin folds from front to back.

11. Wash the inner labia from front to back.

12. Gently open all skin folds and wash the inner area from front to back, exposing urethral and vaginal openings.

13. Rinse the area well, starting with innermost area and proceed outward.

14. Wash and rinse the anal area.

15. Pat the peri area dry.

16. Apply powder lightly to outer peri area (optional).

C. Steps ending procedure

17-22. See steps 15-20 of perineal care for the male client procedure.

VI. Summary and Conclusion

A. Key points of peri care

B. Specific measures related to peri care

C. Classroom discussion

D. Review steps of procedures.

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

______ 1. Perineal

______ 2. Circumcised

______ 3. Foreskin

______ 4. Scrotum

______ 5. Anus

______ 6. Labia

a. Outlet of the rectum

b. Surgical removal of the end of the foreskin of the penis

c. Loose skin at and covering the end of the penis

d. The skin folds which are on both sides of the vagina

e. The area between the pubic bone back and including the anus

f. The pouch containing the testicles

7. List two purposes of giving peri care.

a.

b.

8. Describe two observations you could make while giving peri care.

a.

b.

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 9. You should wash from front to back to prevent spreading fecal matter to the vagina or urethra.

______ 10. It is not necessary to retract the foreskin of an uncircumcised male when doing peri care.

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bed making, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-39 OR DEMONSTRATION: VI-39

PERINEAL CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List two purposes of peri care.
3. Identify two specific observations to make while giving peri care.
4. Demonstrate how to perform perineal care for the male and female clients according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Perineal Area of the Male and Female
2. Trainex filmstrip #342: "Peri Care"
3. Projector
4. Basin of warm water
5. Washcloth (disposable type, if available)
6. Disposable/reusable bed protector
7. Towel
8. Bath blanket
9. Soap and soap dish
10. Powder (optional)

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. e
2. b
3. c
4. f
5. a
6. d
7. a. To clean that area for the client who is unable to or has difficulty with adequately cleaning self
8. a. Unusual discharge odors
9. b. Signs of skin breakdown--redness, irritation
10. F

LESSON PLAN: 39

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

PERINEAL CARE

EQUIPMENT:

1. Basin of warm water
2. Washcloth (disposable type, of available)
3. Disposable/reusable bed protector
4. Towel
5. Bath blanket
6. Soap and soap dish
7. Powder (optional)

DID THE STUDENT	YES	NO
Male Client		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Wear disposable gloves.		
6. Provide privacy.		
B. Peri care procedure		
7. Client should be in supine position; place bed protector under buttocks.		
8. Cover client with bath blanket.		
9. Expose perineal area. Gently wash the penis starting at the tip and moving downward--then rinse.		

DID THE STUDENT	YES	NO
10. Wash and rinse the scrotum.		
11. Wash and rinse other skin areas between the legs.		
12. Wash and rinse the anal area.		
13. Pat the peri area dry.		
14. Apply powder under scrotum to prevent rubbing on skin (optional).		
C. Steps ending procedure		
15. Remove disposable bed protector and bath blanket.		
16. Place call signal within reach, if needed.		
17. Remove, clean and store equipment.		
18. Wash hands.		
19. Record observations, reporting anything unusual to charge nurse.		
Female Client		
A. Steps beginning procedure		
1-6. Complete steps 1-6 of perineal care for male client procedure.		
7. Assist client to supine or side-lying position; place bed protector under buttocks.		
8. Cover client with bath blanket.		
9. Expose perineal area. Gently wash the inner legs and outer peri area along the outside of the labia. NOTE: Use a clean area of washcloth for each swipe.		

DID THE STUDENT	YES	NO
10. Wash the outer skin folds from front to back.		
11. Wash the inner labia from front to back.		
12. Gently open all skin folds and wash the inner area from front to back.		
13. Rinse the area well, starting with innermost area and proceed outward.		
14. Wash the anal area.		
15. Pat the peri area dry.		
16. Apply powder lightly to outer peri area (optional).		
C. Steps ending procedure 17-22. Complete steps 15-20 of perineal care for the male client procedure.		

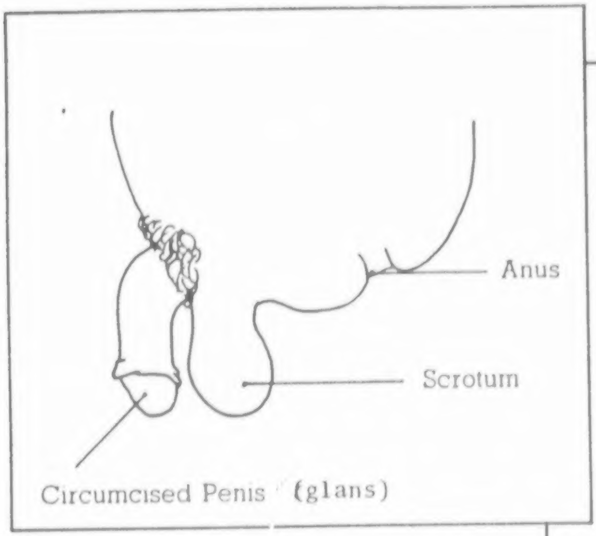
The student has satisfactorily completed the procedure "PERINEAL CARE" according to the steps outlined.

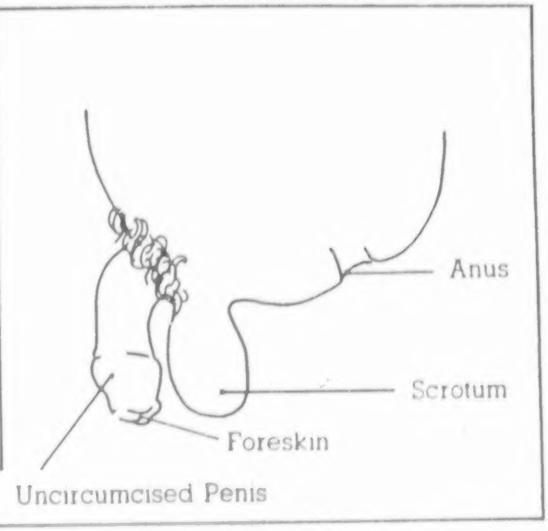
____
Instructor's signature
(Verifying Satisfactory Completion)

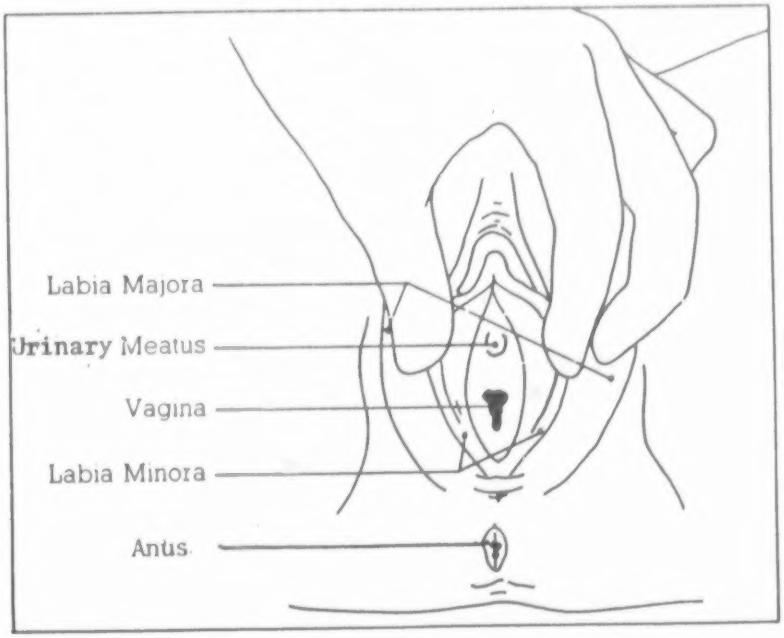
____
Date

PERINEAL AREA OF THE MALE & FEMALE

HO 1


Anus
Scrotum
Circumcised Penis (glans)


Anus
Scrotum
Foreskin
Uncircumcised Penis


Labia Majora
Urinary Meatus
Vagina
Labia Minora
Anus

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-40 OR DEMONSTRATION:

HAIR CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List three purposes of hair care.
2. Identify two observations to make when giving hair care.
3. Recognize three specific measures related to hair care.
4. Demonstrate giving a shampoo during a tub bath/shower bath according to the steps of procedure.
5. Demonstrate giving a bed shampoo according to the steps of procedure.
6. Demonstrate how to comb/brush a client's hair according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Bath towels (2)
2. Face towel/wash cloth
3. Shampoo
4. Hair conditioner/cream rinse (optional)
5. Bath thermometer
6. Pitcher/hand-held shower nozzle
7. Hair dryer for use in client's room
8. Client's personal comb/brush
9. Hand mirror, if available
10. Equipment for bed shampoo:
    a. Shampoo trough/plastic sheet
    b. Large basin/bucket
    c. Bath blanket
    d. Waterproof bed protector
    e. Cotton balls (2)
    f. Small towel
    g. Chair/footstool

TEACHER RESOURCES:

INTRODUCTION:

Proper care and styling of the hair is important to the client's appearance and sense of well-being. It can really make a difference in a person's appearance. The client's physical condition and safety, as well as hair and scalp condition and personal preference may determine frequency and method of shampooing. Shampoos may be given with the tub bath/shower bath. or a bed shampoo may be necessary. Female clients may want their hair set or rolled before drying. It is the duty of the nurse assistant to assist or to care for the client's hair on a daily basis in combing or brushing and arranging it attractively.

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Hair Care

A. Good hair care is important as a morale booster and for maintaining a clean and attractive appearance.

B. Purposes of hair care

1. Clean hair of dirt particles and dead cells; prevent matting.

2. Stimulate circulation of scalp, bringing nutrients to the roots.

3. Improve one's appearance.

C. Hair care should be done at the following times:

1. Combing and brushing should be done in the morning and during the day as needed.

2. Hair should be washed at least weekly for all clients and more often if indicated.

D. Observations to make

1. Sore

2. Redness

3. Dry scalp, excessive dandruff

4. Swollen areas

II. Specific Measures Related to Hair Care

A. Label client's own comb and brush. Simply write client's name with a permanent marker on a piece of adhesive tape and apply to comb or brush.

B. When styling hair, place a towel around client's shoulders to prevent hair from getting into clothes and causing irritation or onto clean, fresh clothes.

C. Be sure to clean comb and a brush after each use.

NOTE: Check institutional policy for procedure used in the facility.

D. After washing the hair, rinse all soap from scalp t prevent irritation and dryness. May use a solution of one part white vinegar to five parts water, then follow with warm water rinse.

E. Avoid using brush curlers interchangably between client's. This can be a source of infection.

F. Use hair dryers with extreme caution; check temperature frequently. If using hand-held dryer, keep your hand under air stream so you will know what the temperature is. Do not use in tub room since it may come in contact with water and cause electrocution.

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for Shampoo with Tub Bath or Shower Bath

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. See that room is free from drafts, preferably 75 degrees Fahrenheit.
4. Identify and great client. Identify self.
5. Explain what you are going to do.
6. Provide privacy.

B. Tub or shower shampoo procedure

7. Adjust water temperature to 105-110 degrees Fahrenheit.
8. Position client appropriately in tub or shower.
9. Ask client to hold folded washcloth/face towel over eyes.
10. Apply water to the hair until it is completely wet using nozzle or pitcher.
11. Apply small amount of shampoo. Work up a good lather, massaging well with fingertips.
12. Rinse thoroughly working from front to back.
13. Repeat sudsing and rinsing if necessary.
14. Apply conditioner or creme rinse as directed on the container. Rinse thoroughly.
15. Wrap client's head with a large bath towel while completing bath or shower.
16. Towel-dry with second towel if necessary.
17. Encourage client to comb own hair, if able.

18. Comb hair to remove snarls and tangles. Apply rollers or set hair if this is to be done.

    NOTE: Client's personal curlers must be used.

19. Dry hair quickly.

    CAUTION: Electrical appliances should not be used in the bathroom and use hair dryer on low temperature setting.

20. When hair is dry, remove curler. Comb or brush hair and arrange attractively.

    NOTE: Use client's personal comb/brush.

21. Let client use the hand mirror; make the client comfortable.

C. Steps ending procedure

22. Place call signal within reach.

23. Remove, clean, store equipment.

24. Wash your hands.

25. Record observations.

    NOTE: Report anything unusual to charge nurse.

IV. Steps of Procedure for Bed Shampoo

A. Steps beginning procedure.

1-6. See III. A., steps 1-6 of shampoo with tub bath or shower bath procedure.

B. Bed shampoo procedure

7. Raise the bed to its highest horizontal position. NOTE: Some clients may require that the head be elevated.

8. Place chair or footstool at the side of the need near the client's head and cover with a small towel. Set large basin or bucket on chair.

9. Move client to side of bed. Cover with bath blanket and fanfold top linens to foot of bed with exposing the client.

10. Remove pillow and replace with waterproof bed protector.

11. Place one towel under client's head and one around shoulders.

12. Place shampoo trough or arrange plastic sheet under head to form a drain into the buckets.

13. Put a cotton ball in each ear of the client.

14. Apply water to hair until it is completely wet using pitcher.

15. Apply small amount of shampoo. Work up a good lather, massaging well with finger tips.

16. Rinse thoroughly, working from front to back.

17. Repeat sudsing and rinsing if necessary.

18. Apply conditioner/creme rinse as directed on container. Rinse thoroughly.

19. Squeeze excess water from hair, apply towel to hair.

20. Remove shampoo trough and place in bucket.

21. Remove cottonballs from client's ears. Using another towel, dry the client's hair.

22. See III. B., steps 17-21 of shampoo with tub bath or shower bath procedure.

C. Steps ending procedure

23-26. See III.C., steps 22-25 of shampoo with tub bath or shower bath procedure.

V. Steps of Procedure to Comb or Brush Hair

A. Steps beginning procedure.

1-6. See III. A., steps 1-6 of shampoo with tub bath or shower bath procedure.

V. Steps of Procedure to Comb or Brush Hair

A. Steps beginning procedure

1-6. See III. A., steps 1-6 of shampoo with tub bath or shower bath procedure.

B. Comb/brush hair procedure

7. Place the client's towel across pillow if the client is in bed. For the sitting client place towel around shoulders.

8. If client wears glasses, remove them to a safe place. Remove hairpins, combs, etc.

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. Why is clean hair important?
2. Why is it necessary to provide a warm, draft-free area?
3. Discuss precautions regarding use of hair dryers?
4. Why is it important to use the client's own brush, comb and curlers?
5. Where is the towel placed when giving hair care to the client in bed?
6. How do you comb or brush the hair?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates shampoo procedures and combing/brushing hair.
2. Students practice arranging each other's hair.

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. List three purposes of hair care.

   a.

   b.

   c.

2. Which of the following is not an appropriate observation while doing hair care? (Circle the letter of the correct answer.)

   a. Sores
   b. Redness of scalp
   c. Needs to be dyed
   d. Excessive dandruff

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 3. The comb and brush should only be cleaned when full of hair.

_______ 4. Brush curlers used among several clients could be a source of infection.

_______ 5. Hair dryers should never be used in a tub room or near a sink.

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. a. Stimulate circulation of scalp, bringing nutrients to the roots
   b. Cleans hair of dirt particles and dead cells; prevent matting.
   c. Improves one's appearance
2. c
3. F
4. T
5. T

LESSON PLAN: 40

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ______________________

HAIR CARE

EQUIPMENT:

1. Bath towels
2. Washcloths (2)
3. Shampoo
4. Hair conditioner/creme rinse (optional
5. Bath thermometer
6. Pitcher/hand-held shower nozzle
7. Hair dryer for use in resident's room
8. Resident's personal comb/brush
9. Hand mirror, if available
10. Equipment for bed shampoo:
    - a. Shampoo trough/plastic sheet
    - b. Large basin/bucket
    - c. Bath blanket
    - d. Waterproof be protector
    - e. Cotton balls
    - f. Small towel
    - g. Chair/footstool

DID THE STUDENT	YES	NO
Shampoo with Tub Bath or Shower		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary equipment.		
3. See that room is free from drafts, preferably 75-80 degrees Fahrenheit.		
4. Identify and greet client. Identify self.		
5. Explain procedure to client.		
6. Provide privacy.		
B. Tub bath procedures		
7. Adjust water temperature to 105-110 degrees Fahrenheit.		

DID THE STUDENT	YES	NO
8. Position client appropriately in tub or shower.		
9. Ask client to hold folded washcloth/face towel over eyes.		
10. Apply water to hair until it is completely wet using NOTE: If using nozzle, keep one finger in stream of water to assure correct temperature of water.		
11. Apply small amount of shampoo. Work up a good later, massaging well with fingertips.		
12. Rinse thoroughly working from front to back.		
13. Repeat sudsing and rinsing if necessary.		
14. Apply conditioner or creme rinse as directed on the container. Rinse thoroughly.		
15. Wrap client's head with a large bath towel while completing bath or shower.		
16. Towel-dry with second towel if necessary.		
17. Encourage client to comb own hair, if able.		
18. Comb hair to remove snarls and tangles. Apply rollers or set hair if this is to be done.		
19. Dry hair quickly.		
20. When hair is dry, remove curlers. Comb or brush hair and arrange attractively.		
21. Let client use the hand mirror; make the client comfortable.		

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Nail Care

   A. Purpose of nail care

      1. Decrease bacteria build-up under nails which could cause infections.
      2. Give the client a neat appearance.
      3. Prevent cuts/scratches from long nails.

   B. Nail care should be done as needed for each client; nails grow at different rates for each person.

   C. Observations to make

      1. Cuts
      2. Callouses, corns
      3. Changes in skin color
      4. Complaint of tenderness
      5. Swelling of feet and legs.

II. Specific Measures Related to Nail Care

   A. Make sure you have a good source of light to enable you to see what you are doing.

   B. Trim/file nails after bath/soaking in water since this will make them softer. Do not trim too close to the flesh.

   C. Dry thoroughly between toes and fingers; excess moisture can lead to skin breakdown.

   D. A licensed nurse or podiatrist (a physician specialized in the care of feet) should be responsible for nail care of client who is diabetic or who has impaired circulation. Follow H.H.A. policy regarding cutting toe and fingernails (CD-8) (CD-9)

   E. Ambulatory clients should wear good, supportive shoes and stockings, rather than house slippers.

   F. Avoid use of garters, they restrict circulation.

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

III. Steps of Procedure for Fingernail Care.

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.

   NOTE: This should include a supplementary light, if necessary, to provide a well lit working area.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.

B. Fingernail care procedure

5. If client is in bed, raise the back rest. Place disposable bed proctector under the hands, then place towel on top of bed protector.
6. If client is in chair, lower over bed table; place table front of client with disposable bed protector on top, then place towel on top of bed proctector.
7. Place basin of soapy water on the towel.
8. Soak the fingers in the warm, soapy water for five minutes. You may soak one hand at a time or soak both at the same time. (CD-2)
9. Rinse hands with clear, warm water and dry with the towel. Remove basin when finished soaking.
10. Place towel under client's dried hands.
11. Gently remove dirt from around and under each fingernail with an orange stick or nail file. Use paper towel to clean orange stick. (CD-3) (CD-4)
12. Trim nails (if needed) in an oval shape, according to facility or agency policy. (CD-1)
13. Smooth nails with an emery board or file.
14. Rub lotion on hands.

15. Repeat steps 9-14 on other hand.

16. Have client exercise hands by alternately stretching them and making a fist.

C. Steps ending procedure

17. Make client comfortable; place call signal with in reach, if needed.

18. Remove, clean, and store equipment.

19. Wash your hands.

20. Record observations.

NOTE: Report anything usual to charge nurse.

IV. Steps of Procedure for Toenail Care

A. Steps beginning procedure

1-4. See III. A., steps 1-4 of fingernail care procedure.

B. Toenail care procedure

5-11. See III. B., steps 5-11 of fingernail care procedure, and instead of hands refer to feet. (CD-7)

12. Trim nails (if needed) straight across and only if your facility or agency allows a N.A. to do this procedure. (CD-6)

13. Smooth nails with an emery board of file.

14. Rub lotion on feet and legs using upward strokes.;

15. Repeat steps 8-14 of fingernail care procedure on other foot.

16. Have resident exercise feet by raising and lowering legs while sitting in a chair; wiggling toes; turning ankles in and out.

C. Steps ending procedure

17-20. See III. C., steps 17-20 of fingernail procedure.

V. Summary and Conclusion

A. Key points of nail care

B. Specific measures related to nail care

C. Classroom discussion

D. Review steps of procedure

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. What is the proper way to shape fingernails?
2. How do you instruct the client to exercise his/her hands?
3. Why is it important that the client's fingernails be clean and trimmed?
4. In what type of water are the feet soaked?.
5. What do you use to clean under the nail bed and around the nails?
6. How are the toenails shaped?
7. How long are the feet soaked?
8. Why does only the nurse or podiatrist cut the toenails of a diabetic client or client with poor circulation?
9. What can happen to a skin injury of a diabetic client's foot?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates fingernail and toenail care.
2. Students practice fingernail and toenail care on each other.

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

NAIL CARE

EQUIPMENT:

1. Wash basin - 3/4 full of warm, soapy water.
2. Pitcher of warm water.
3. Towel and paper towel.
4. Disposable/reusable bed protector.
5. Orange stick/flat toothpick.
6. Emery board/nail file.
7. Nail clippers.
8. Lotion.

DID THE STUDENT	YES	NO
Fingernail Care Procedure		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment (including supplementary lighting, if necessary.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
B. Fingernail care procedure		
5. If client is in bed, raise the back rest. Place disposable bed protector on top, then place towel on top of bed protector.		
6. If client is in chair, lower over bed table; place table in front of client with disposable bed proctector under hands, then place towel on top of bed protector.		
7. Place basin of soapy water on the towel.		
8. Soak fingers in the warm soapy water for five minutes. Soak one hand at a time or soak both at same time.		
9. Rinse hands with clear, warm water and dry with the towel. Remove basin when finished soaking.		

DID THE STUDENT	YES	NO
C. Steps ending procedure		
22. Place call signal within reach, if needed.		
23. Remove, clean, store equipment.		
24. Wash hands.		
25. Record observations, report anything unusual to charge nurse.		
Bed Shampoo		
A. Steps beginning procedure		
1-6. Complete steps 1-6 of shampoo with tub bath or shower procedure.		
B. Bed Shampoo procedure		
7. Raise the bed to its highest horizontal position.		
8. Place chair or footstool at the side of bed near the client's head and cover with a small towel. Set large basin or bucket on chair.		
9. Move client to side of bed. Cover with bath blanket and fanfold top linens to foot of bed without exposing client.		
10. Remove pillow and replace with waterproof bed protector.		
11. Place one towel under client's head and one around shoulders.		
12. Place shampoo trough or arrange plastic sheet under head to form a drain into bucket.		
13. Put a cotton ball in each ear of the client.		

DID THE STUDENT	YES	NO
14. Apply water to hair until it is completely wet using pitcher.		
15. Apply small amount of shampoo. Work up a good lather, massaging well with fingertips.		
16. Rinse thoroughly, working from front to back.		
17. Repeat sudsing and rinsing if necessary.		
18. Apply conditioner/creme rinse as directed on container Rinse thoroughly.		
19. Squeeze excess water from hair, apply towel to hair.		
20. Remove shampoo trough and place in bucket.		
21. Remove cotton balls from client's ears. Using another towel, dry the client's hair.		
22-26. Complete steps 17-21 of shampoo with tub bath or shower procedure.		
C. Steps ending procedure 27-29. Complete steps 2-25 of shampoo with tub bath or shower procedure.		
Comb or Brush Hair A. Steps beginning procedure 1-6. Complete steps 1-6 of shampoo with bath or shower procedure.		
B. Comb/brush hair procedure 7. Place the client's towel across pillow if the client is in bed. For the sitting client place towel around shoulders.		

DID THE STUDENT	YES	NO
8. If client wears glasses, remove them to a safe place. Remove hairpins, combs, etc.		
9. Brush or comb hair gently using downward strokes starting at ends first, working toward the scalp.		
10. Arrange hair attractively to the client's satisfaction. Braiding is suggested for clients with long hair. This prevents tangling.		
11. Let client use the hand mirror.		
C. Steps ending procedure 12-15. Complete steps 22-25 of shampoo with tub bath or shower procedure.		

The student has satisfactorily completed the procedure "HAIR CARE" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-41 OR DEMONSTRATION: VI - 41

NAIL CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List two purposes of nail care.
2. Identify three observations to make when giving nail care.
3. Recognize three specific measures related to nail care.
4. Demonstrate how to give fingernail care according to the steps of procedure.
5. Demonstrate how to give toenail care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Wash basin - 3/4 full of warm, soapy water.
2. Pitcher of warm water.
3. Towel and paper towel.
4. Disposable/reusable bed protector.
5. Orange stick/flat toothpick.
6. Emery board/nail file.
7. Nail clippers.
8. Lotion.

TEACHER RESOURCES:

INTRODUCTION:

Nail care is an important aspect of the personal care of the client. It includes cleaning and trimming the fingernails and toenails on a regular basis. The part of the nail we see is not living tissue; but the skin around and under the nail is living tissue and needs to be protected from injury or infection. Toenails tend to be thicker than fingernails, particularly as a person ages. (Follow the nail care procedure directions of your supervisor.) If you have difficulty trimming them, report this to the charge nurse. This may be a new experience for you. Just take your time and follow the next procedure.

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. List two purposes of nail care

   a.

   b

2. It is important for the nurse assistant to observe for the following when performing nail care: (Circle the letter of the correct answer.)

   a. Callouses
   b. Swelling of feet
   c. Cuts
   d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

______ 3. Nails should be trimmed after soaking in water since this makes them softer.

______ 4. The diabetic client's nails should be trimmed only by the nurse or podiatrist.

______ 5. Garters are an aid to circulation of the legs.

LESSON PLAN: 41

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. a. Give the client a neat appearance.
2. b. Prevent cuts/scratches from long nails.
3. T
4. T
5. F

DID THE STUDENT	YES	NO
10. Place towel under client's dried hands.		
11. Gently remove dirt from around and under each fingernail with an orange stick or nail file. Use paper towel to clean orange stick.		
12. Trim nails (if needed) in an oval shape.		
14. Rub lotion on hands.		
15. Repeat steps 9-14 on other hand.		
16. Have client exercise hands by alternately stretching them and making a fist.		
C. Steps ending procedure		
17. Make client comfortable; place call signal within reach, if needed.		
18. Remove, clean, and store equipment.		
19. Wash hands.		
20. Record observations and report anything unusual to charge nurse.		
Toenail Care Procedure		
A. Steps beginning procedure		
1-4 Complete steps 1 through 4 of fingernail care procedure.		

	YES	NO
B. Toenail Care Procedure		
5-11. Complete steps 5 through 11 of fingernail care procedure; instead of hands refer to feet.		
12. Trim nails (if needed) straight across only if facility or agency allows N.A. to do procedure.		
13. Smooth nails with an emery board or file.		
14. Rub lotion on feet and legs in upward motion.		
15. Repeat steps 8-14 of fingernail care procedure on other foot.		
16. Have the client exercise feet by raising and lowering legs while sitting in a chair; wiggling toes; turning ankles in and out.		
C. Steps ending procedure		
17-20. Complete steps 17 through 20 of fingernails care procedure.		

The student has satisfactorily completed the procedure "NAIL CARE" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

C. Steps ending procedure

16. Remove, clean (if garment is soiled), and store removed clothes.

17. Wash your hands.

18. Record observations.

NOTE: Report anything unusual to charge nurse.

II. Steps of Procedure for Undressing the Client

A. Steps beginning procedure

1-5. See steps 1-5 of dressing the client procedure.

B. Undressing procedure

6. Assist client from chair to the bed; if he/she is able, have client sit on side of bed. If unable, help client to lie down.

7. Remove shoes (if client will be lying down).

   a. Loosen shoelaces, pull tongue of shoe forward and up.

   b. Support ankle and slide foot out of shoe.

   c. Store shoes in closet.

8. Remove stockings.

   a. Roll stocking down to ankle.

   b. Support ankle and slide stocking off foot.

9. Pullover sweater/shirt

   a. Loosen first (unzip/unbutton) and grasp the bottom of garment at back and pull to the neck.

   b. Pull over head

   c. Then pull off of the arms.

10. Dress/shirt

   a. Loosen first and remove the sleeve of garment from the strong arm.

   b. If client is lying down, then roll client and tuck the half-removed garment under client.

c. Return client to back; turn him/her slightly in the opposite direction; grasp the garment and pull out.

d. Remove garment from weak arm.

e. Follow same sequence if client is sitting up.

11. Slacks/pants/underpants

a. Unfasten pants at waist and unzip.

b. Have client stand if able to pull pants off legs.

c. If client is lying down, have him/her lift hips up and slip pants down over buttocks. If client is unable to do this, roll client toward you, slip pants down over hip, then turn to back and to opposite side and pull pants down over other hip.

d. Return client to back and slide pants down over legs and pull off feet.

e. Remove shoes and stockings if client was standing.

12. Undershirt/slip is removed following steps for pullover sweater/shirt.

13. Brassiere

a. Unfasten bra/assist client to unfasten bra.

b. Slip arms out of shoulder straps.

14. Assist/have client put on gown or pajamas.

15. Assist client to bed if not in bed.

16. Place call signal within reach. (CD-4)

C. Steps ending procedure

17-19. See steps 16-18 of dressing the client procedure.

III. Summary and Conclusion

A. Key points of dressing and undressing

B. Classroom discussion

C. Review steps of procedures.

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

CLASSROOM DISCUSSION:

1. Which arm should be placed in garment first if the client has a non functioning/weak side?
2. What clothes can you put on the client before sitting up?
3. Why do you have clients put on shoes before standing?
4. What should always be done after the client has been undressed and put to bed?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates dressing and undressing a client. (May have a student put on clothing over his/her own clothing if Chase doll not available)
2. Students practice dressing and undressing procedure.

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS:

1. Elderly clients may feel colder due to: (Circle the letter of the correct answer.)

   a. Senility
   b. Inadequate heating systems
   c. Poorer circulation and less fat
   d. Because they like to complain

2. Complete dress includes: (Circle the letter of the correct answer.)

   a. Underwear
   b. Shoes and stockings
   c. Sweaters and jackets
   d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

_______ 3. Always dress clients who are handicapped with clothes on backwards since it is easier to get them on and off.

_______ 4. Dress the client with clean clothes after bathing.

_______ 5. It is not the nurse assistant's responsibility to send clothing to the appropriate department for mending.

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

ANSWERS TO EVALUATION ITEMS:

1. e
2. d
3. F
4. T
5. F

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

EVALUATION ITEMS: NAME OF STUDENT: ____________________

DRESSING AND UNDRESSING

EQUIPMENT:

1. Articles of clothing appropriate for proper dress of client.

DID THE STUDENT	YES	NO
Dressing the Client		
A. Steps beginning procedure		
1. Wash hands.		
2. Arrange necessary clothing.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Dressing procedure		
6. Assist client in removing gown, pajamas, or soiled clothing.		
7. If client is in bed, put on underclothes, stockings and slacks while lying down.		
8. Brassiere		
a. If client can assist, place around her chest so fasteners are in front; fasten bra.		
b. Shift it around so fasteners are in back.		

	YES	NO
c. Instruct client to slip arms through the shoulder straps.		
9. Undershirt/slip a. Assist or have client put head into undershirt/slip first.		
b. Assist or have client put head into undershirt/slip.		
c. Check and make sure undershirt/slip does not remain rolled up on client's back--pull down waist.		
10. Stockings/socks a. Roll the stocking down from the opening to just beyond the heel.		
b. Support client's ankle and slip rolled stocking over the the toes; position it over the heel, and pull it up smoothly over the leg.		
11. Underpants/slacks/pants a. Put both legs in pants; slide up to hips.		
b. Have client lift his/her hips and pull pants up. If client is unable to, turn to one side and slip pants over hip, then turn to opposite side and pull pants over hip.		
c. Zip the zipper and fasten (if applicable).		
d. If client has catheter leave the fly open to allow for supine, then pin the fly shut.		
12. Shoes a. Always help client put shoes on before standing up from bed to avoid slipping on floor.		

	YES	NO
b. Loosen laces and pull tongue of shoe forward and up.		
c. Support client's ankle as you slide toe toes, foot and heel into the shoe.		
d. If possible, have client stand and tie shoelaces.		
13. Raise the head of the bed to a near sitting position; or assist client into a sitting position on side of bed or to a chair at bedside.		
14. Dress/shirt a. Assist/have client put weak arm in sleeve of garment first while there is more "give."		
b. Put other arm in next.		
c. If both arms are weak, put dress on over feet, then put arms in sleeves.		
15. Pullover sweater/shirt a. Put on like undershirt.		
C. Steps ending procedure 16. Remove, clean if garment soiled and store removed clothes.		
17. Wash hands		
18. Record observations and report anything unusual to charge nurse.		
Dressing the Client A. Steps beginning procedure 1-5 Complete steps 1-5 of dressing the client procedure.		

	YES	NO
B. Undressing procedure 6. Assist client from chair to the bed; if he/she is able have able, have client sit on side of bed. If unable, help client to lie down.		
7. Remove shoes (if client will be lying down). a. Loosen shoelaces, pull tongue of shoe forward and up.		
b. Support ankle and slide foot out of shoe.		
c. Store in closet.		
8. Remove stockings. a. Roll stocking down to ankle.		
b. Support ankle and slide stocking off foot.		
9. Pullover sweater/shirt a. Loosen first (unzip/unbutton) and grasp the bottom of garment at back and pull on the neck.		
b. Pull over head.		
c. Then pull off the arms.		
10. Dress/shirt a. Loosen first and remove the sleeve of garment from the strong arm.		
b. If client is lying down, then roll client and tuck the half-removed garment under client.		
c. Return client to back; turn him/her slightly in the opposite direction; grasp the garment, and pull out.		
d. Remove garment from weak arm.		

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

SCOPE OF UNIT:

This unit covers all aspects of personal care that affect a client's personal hygiene and general comfort. It includes the following procedures: bathing, bedmaking, oral hygiene, shaving, skin care, peri care, hair care, nail care, dressing, and undressing.

INFORMATION TOPIC: VI-42 OR DEMONSTRATION: VI-42

DRESSING AND UNDRESSING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify five key points of dressing and undressing.
2. Demonstrate how to assist the client to dress and undress according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Articles of clothing appropriate for proper dress of client.

TEACHER RESOURCES:

INTRODUCTION:

An essential part of good grooming is wearing appropriate, clean and neat clothing. Allow the client to choose what to wear. If the client has difficulty making decisions, don't open the closet and expect him/her to pick something out. Rather, you suggest two different outfits and let him/her choose one. This allows the client to make some decisions. The client because of illness or disability, may not be able to get dressed independently. You, as a nurse assistant, will then be responsible for doing so. Remember the importance of allowing the client to do anything that he/she can. This will reduce feelings of being so dependent upon others.

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

I. Key Points of Dressing and Undressing

A. Supervise appropriate dress depending upon weather and occasion. Dress as he/she requests, if reasonable.

B. Assure complete dress depending upon client.

1. Underwear - bra, panties, or T-shirt, shorts
2. Shoes and stockings - for warmth and proper support
3. Sweaters and jackets - this is appropriate for older adults even in the summer since they may feel colder.
4. Lap robe - for clients in g/c or w/c and with a catheter

C. Dress with clean clothes after bathing and at any time clothing is soiled.

D. Encourage clothes that open down the front for handicapped clients.

E. Do not put clothes on backwards. This is not appropriate.

F. Be aware of those clients whose families do their laundry. Place soiled clothes in proper hamper.

G. All personal clothing should have name tags sewn in or should be marked with ink that will not wash out. Avoid marking where name will show when garment is worn.

H. Send clothing to appropriate department if it needs to be mended. Clients should not have to wear clothing that is in need of repair.

LESSON PLAN: 42

COURSE TITLE: NURSE ASSISTANT

UNIT VI : PERSONAL CARE

II. Steps of Procedure for Dressing the client

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary clothing.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

B. Dressing procedure

6. Assist client in removing gown, pajamas, or soiled clothing.
7. If client is in bed, put on underclothes, stockings and slacks while lying down.
8. Brassiere
    a. If client can assist, place around her chest so fasteners are in front.
    b. Shift it around so fasteners are in back.
    c. Instruct client to slip arms through the shoulder straps.
9. Undershirt/slip
    a. Assist or have client put arms into undershirt/slip first.
    b. Assist/have client put head into undershirt/slip.
    c. Check and make sure undershirt/slip does not remain rolled up on client's back--pull down to waist.

10. Stockings/socks

    a. Roll the stocking down from the opening to just beyond the heel.

    b. Support client's ankle and slip rolled stocking over the toes; position it over the heel, and pull it up smoothly over the leg.

11. Underpants/slacks/pants

    a. Put both legs in pants; slide up to hips.

    b. Have client lift his/her hips and pull pants up. If client is unable to, turn to one side and slip pants over hip, then turn to opposite side and pull pants over hip.

    c. Zip the zipper and fasten (if applicable).

    d. If client has catheter, leave the fly open to allow for tubing, then pin the fly shut. (CD-3)

12. Shoes

    a. Always help client put shoes on before standing up from bed to avoid slipping on floor.

    b. Loosen laces and pull tongue of shoe forward and up.

    c. Support client's ankle as you slide the toes, foot and heel into the shoe.

       NOTE: Use a shoehorn if available.

    d. If possible, have client stand and then tie shoelaces.

13. Raise the head of the bed to a near sitting position; or assist client into a sitting position on side of bed or into a chair at bedside.

14. Dress/shirt

    a. Assist/have client put weak arm in sleeve of garment first while there is more "give".

    b. Put other arm in next.

    c. If both arms are weak, put dress on over feet, then put arms in sleeves.

15. Pullover sweater/shirt is put on like undershirt.

	YES	NO
e. Follow same sequence if client is sitting up.		
11. Slacks/pants/underpants a. Unfasten pants at waist and unzip.		
b. Have client stand if able and pull pants off legs.		
c. If client is lying down, have him/her lift hips up and slip pants down over buttocks. If client is unable to do this, roll toward you, slip pants down over hip, then turn to back and to opposite side and pull pants down over other hip.		
d. Return client to back and slide pants down over legs and pull off of feet.		
e. Remove shoes and stockings if client was standing.		
12. Undershirt/slip - remove following steps for pullover sweater/shirt.		
13. Brassiere a. Unfasten bra/assist client to unfasten bra.		
b. Slip arms out of shoulder straps.		
14. Assist/have client put on gown or pajamas.		
15. Assist client to bed if not in bed.		
16. Place call signal within reach.		
C. Steps ending procedure 17-19. Complete steps 16-18 of dressing the client procedure.		

The student has satisfactorily completed the procedure "DRESSING AND UNDRESSING" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 43

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: VII-43 OR DEMONSTRATION:

ELIMINATION OF URINE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify two factors which maintain urine elimination.
3. Describe the characteristics of normal urine.
4. Identify three conditions that may cause abnormal urine elimination.
5. Identify three factors that can lead to urinary incontinence.
6. List two special measures for abnormal urinary function.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Catheters
2. Trainex filmstrip #338: "Assisting Your Patient with Urine Elimination"
3. Projector
4. Indwelling catheter
5. External catheter

TEACHER RESOURCES:

INTRODUCTION:

Elimination of urine is one of the body's basic functions. The elimination system must work properly to rid the body of wastes; if not, the client will become very ill. The nurse assistant must be aware of the importance of proper fluid intake and the need to get all clients to the toilet as often as necessary. It is difficult at times to accomplish this, but every attempt should be made.

LESSON PLAN: 43

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

OUTLINE (Key Points)

I. Terms and Definitions

- A. Bladder - a muscular sac that stores the urine in the body
- B. Catheter - a sterile tube inserted into bladder to drain urine
- C. Incontinent - inability to control evacuation of one's bowels or bladder or both
- D. Kidneys - filtering system of the body
- E. Sphincter muscles - a circle of muscle fibers around the outlet of the urethra and rectum which are normally closed but can be relaxed to allow passage of urine and stool
- F. Ureters - tubes that carry urine from kidneys to bladder
- G. Urethra - the small passage from the bladder through which urine leaves the body
- H. Urinate - to pass urine (also micturate or void)

II. Normal Urine Elimination

- A. Factors which maintain urine elimination
  - 1. Fluids
    - a. The body needs an adequate intake of fluids for proper functioning of the urinary system.
    - b. Nursing responsibilities
      - 1) Ensure adequate intake of 2,000-3,000 cc's of fluid per 24 hours (2-3 quarts) (CD-1_
      - 2) Most fluids should be given between 7 a.m. and 7 p.m. to prevent resident from having to get up during the night to void.

2. Habits/pattern

   a. The body usually gives sensation to eliminate urine every two to three hours if intake is adequate.

   b. Nursing responsibilities

      1) Find out where and how often the client usually voids.

      2) Try to follow established routine and respect privacy.

B. Normal urine characteristics

   1) Color - straw yellow

   2) Clarity - clear, free of sediment and mucus

   3) Amount - usual amount voided is 300-500 ml

   4) Odor - none, except with certain liquids such as coffee

   5) Frequency - depends on fluid intake, most people void at least every three hours

III. Conditions That May Cause Abnormal Urine Elimination

A. Infection of kidney or bladder

   1. Symptoms

      a. Blood in urine - dark red or bright red

      b. Change in normal characteristics of urine - dark yellow, cloudy, or foul odor

      c. Client complains of burning upon urination

      d. Client complains of pain (location depends on where infection is) (CD-2)

      e. Changes in vital signs (increased temperature, increased pulse and respiration)

   2. Nurse assistant responsibilities

      a. Report any of the above to the charge nurse.

b. Ensure adequate fluid intake; force fluids if indicated by charge nurse.

c. Prevent infection by:

1) Encourage adequate fluid intake, especially of water and fruit juices.

2) Encourage client to urinate at least every three to four hours while awake.

3) Assure proper hygiene of perineal area; daily washing and proper wiping from front to back for female client.

B. Retention - inability to empty bladder caused by poor muscle tone of bladder, obstruction of urethra, or damage to certain areas of nervous system

1. Symptoms

a. Client complains of difficulty passing urine

b. Client complains of feeling of fullness in the bladder

c. Client urinates in very small amounts and frequently

2. Nurse assistant responsibilities

a. Report any of the above to the charge nurse.

b. Try triggering mechanisms to help client relax and allow the sphincter muscle to open and release urine.

1) Sound of running water

2) Pouring warm water over the perineal area

3) Putting client's hand in warm water

c. Assist the charge nurse with catherization procedure if indicated.

C. Incontinence - inability to stop or control the passage of urine (CD-3)

1. Factors that can lead to incontinence

a. Confusion - unable to understand where or when he/she is urinating

b. Poor fluid intake - concentrated urine is irritating and causes frequent dribbling

c. Sphincter muscle weakness causes bladder to release urine unexpectedly

d. Damage to nerves in bladder which prevents stimulation of a full bladder from signaling the brain

e. Damage to brain which prevents person from feeling urge to urinate

f. Dribbling after catheter removal due to irritation and reduction in the size of the bladder.

g. Limited mobility and lack of assistance in getting to the bathroom

2. Nurse assistant responsibilities

a. Ensure adequate fluid intake.

b. Assist with bladder training program; may need to get client up during the night or take to the bathroom more frequently than normal (every one to two hours).

IV. Special Measures for Abnormal Urinary Function

A. Indwelling catheter - a sterile tube inserted through the urethra into the bladder to drain urine; held in place by a small inflated balloon (HO 1)

1. Must be ordered by physician and inserted only by a licensed nurse (CD-4)

2. Conditions that require catherization

a. Relief of a partial obstruction in the urethra causing urinary retention

b. Some clients who are paralyzed

c. Clients in a coma

d. Incontinence which is leading to skin breakdown of the peri area

3. Important points about catheters

   a. The bladder is considered sterile; the catheter and drainage tube and bag are a sterile system--this system is not to be opened except when the catheter or bag must be changed. If the system is opened, germs may enter which could lead to an infection.

      1) Drainage tubing/bags should not be allowed to touch the floor; always hook to bedrail or chair; should never be above level of client's bladder.

      2) When the bag is emptied, the drainage tube should not be allowed to touch the rim of the urinal container, the floor, or left out of its pouch while the urinal is being emptied. Wear disposable gloves during procedure. Hands must be washed every time a catheter bag is emptied.

      3) Drainage bag should be changed p.r.n. as directed by the charge nurse.

      4) Drainage bag should be emptied when it starts getting full or at the endl of a shift; record amount emptied.

   b. The urine drains by the principle of gravity.

      1) The catheter and tubing should always be free of bends or kinks.

      2) Tubing should always be coiled or looped instead of hanging loosely. Prevent tubing from hanging below the level of the drainage bag.

      3) The system should always be below the level of the bladder; if moved above, urine could flow back into the bladder.

   c. The catheter tubing should never be pulled on.

      1) Taping it loosely to inner thigh/using a leg band helps prevent this.

      2) When transferring clients from bed to chair, always move drainage bag over to chair before moving client. Do not step on tubing.

B. Texas/external catheter - may only be used for male clients; a condom-type device attached to the penis with a drainage bag (HO 2)

  1. Nurse assistant may apply or assist client--this is not a sterile system; use clean technique. Wear disposable gloves during procedure.

  2. Various types available, follow directions for applying that come with catheter.

  3. Client will require daily peri care.

V. Summary and Conclusion

  A. Terms and definitions

  B. Normal urine elimination

  C. Conditions that may cause abnormal urine elimination

  D. Special measures for abnormal urinary function

It is our goal to properly maintain this basic body function for each of our clients. Incontinence should not be assumed when one talks about the elderly. Many of our clients just need guidance and support in regaining control of this function. Keep in mind the importance of your observation skills. It may be up to your four senses to detect a problem. Wear disposable gloves during procedures.

LESSON PLAN: 43

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

CLASSROOM DISCUSSION:

1. If the fluid intake is between 1,500 to 2,000 ml per 24 hours, what do you expect the output to be in 24 hours?
2. Where would you expect pain to be if the client has a kidney infection?
3. Are most elderly people incontinent?
4. Why does a licensed nurse have to insert an indwelling catheter?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Show students internal and external catheters.

LESSON PLAN: 43

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

____1.	Bladder	a.	The small passage from the bladder to the outside of the body
____2.	Catheter	b.	Filtering system of the body
____3.	Incontinent	c.	Circle of muscle fibers around the urethra
____4.	Kidneys	d.	Tubes that carry urine from kidneys to bladder
____5.	Sphincter muscles	e.	Sterile tube inserted into bladder to drain urine
____6.	Ureters	f.	Inability to control passage of urine
____7.	Urethra	g.	Muscular sac that stores the urine in the body
____8.	Void	h.	To pass urine, micturate, urinate

9. List two factors that help to maintain normal urine elimination.

   a.

   b.

10. Describe the characteristics of normal urine.

11. Which of the following is not a condition that may cause abnormal urine elimination? (Circle the letter of the correct answer.)

    a. Infection of bladder
    b. Incontinence
    c. Retention
    d. Constipation

12. List two special measures for abnormal urinary function.

a.

b.

For each of the following, write "T" if the statement is true, or "F" if the statement is false.

_____13. Confusion may lead to urinary incontinence.

_____14. Proper fluid intake is another cause of incontinence.

_____15. Damage to the brain may prevent a client from feeling the urge to urinate and can cause incontinence.

LESSON PLAN: 43

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

ANSWERS TO EVALUATION ITEMS:

1. g

2. e

3. f

4. b

5. c

6. d

7. a

8. h

9. a. Adequate fluid intake
   b. Adhering to habits/patterns already established

10. Straw yellow in color; clean, free of sediment and mucus; usual amount voided is 300-500 ml.; no odor (except with liquids such as coffee); frequency depends on fluid intake, most people void at least every three hours

11. d

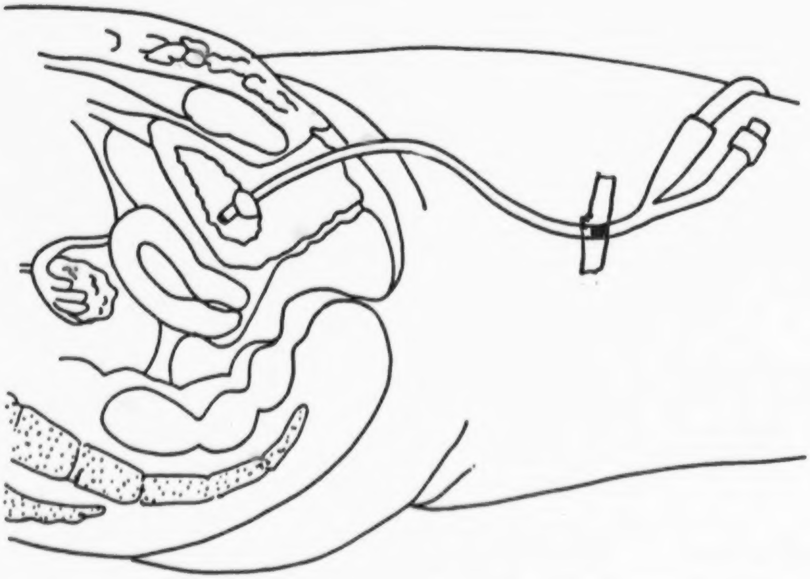
12. a. Indwelling catheter
    b. Texas/external catheter

13. T

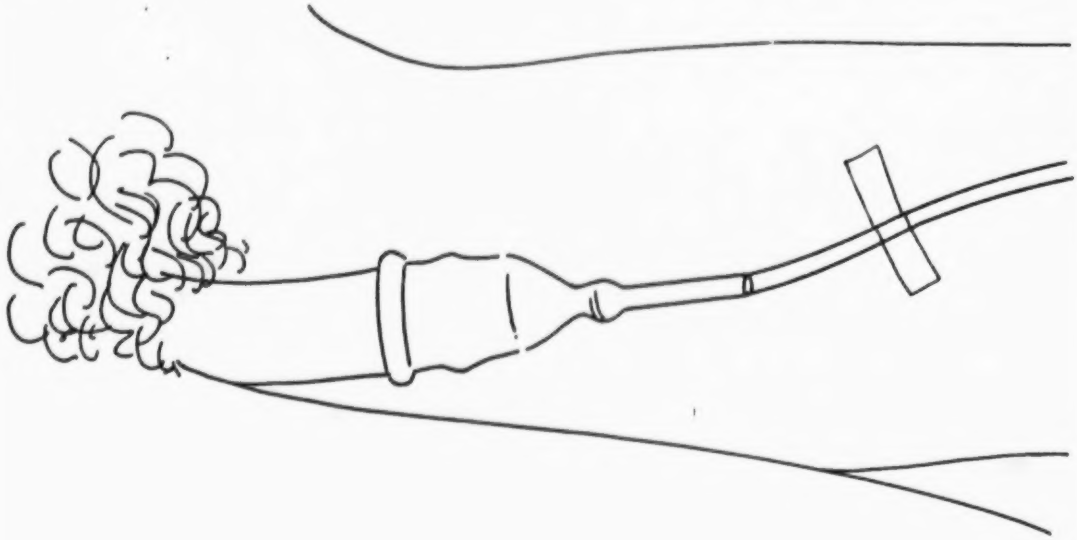
14. F

15. T

INDWELLING CATHETER



EXTERNAL CATHETER



LESSON PLAN: 44

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: OR DEMONSTRATION VII-44

CATHETER CARE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to give catheter care according to the steps of procedure.
2. Demonstrate how to change a drainage bag according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Chase doll (if available)
2. Basin - 1/2 full of warm water
3. Washcloths (2)
4. Mild soap
5. Disposable or reusable bed protector
6. Towel
7. Bath blanket

TEACHER RESOURCES:

INTRODUCTION:

When taking care of clients with catheters keep in mind the basic principles of gravity and infection control. It is the nurse assistant's responsibility to check the catheter to see that it is draining properly, to keep the perineal area clean, to note changes in the urine, and to empty the drainage bag. All of these things are part of catheter care. This lesson will cover daily care of the catheter and perineal area and the procedure for changing the drainage bag or applying a leg bag which is more comfortable for the ambulatory client.

LESSON PLAN: 44

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

STEPS OF PROCEDURE:

Catheter Care

A. Steps beginning procedure

1. Wash your hands.

2. Assemble necessary equipment.

3. Identify and greet client. Identify self.

4. Explain what you are going to do.

5. Provide privacy.

B. Catheter care procedure

6. Client should be in supine position with legs apart; place bed protector under buttocks and between legs.

7. Cover client with bath blanket, then remove top sheet.

8. Check catheter and drainage bag for leaks, kinks, level of bag, character of urine, and that it is securely attached to bed frame. (CD-1)

9. Wearing disposable gloves, expose the perineal area.

   a. Separate the labia of the female client and gently wash around the opening of the urethra with soap and warm water. (CD-2)

   b. Gently pull back the foreskin of the male client and gently wash around the opening of the urethra with soap and warm water.

10. Wash the catheter tubing from the opening of the urethra outward four inches. Do not pull on the catheter. (CD-3)

11. Using a fresh washcloth continue washing, rinsing, and drying the perineal area, (follow procedure in lesson plan 39, Perineal Care, IV. B., steps 9-13 for the male resident and V. B., steps 9-15 for the female resident.)

12. Remove bed protector and bath blanket.

C. Steps ending procedure

13. Remove, clean, and store equipment.

14. Wash your hands.

15. Make the client comfortable; place call signal within reach.

16. Record observations.

NOTE: Report anything unusual to the charge nurse.

Changing the Drainage Bag

A. Steps beginning procedure

1-5. See steps 1-5 of catheter care procedure.

B. Changing the bag procedure

6. If applying a reusable leg bag, swab the end to be connected with alcohol and place on sterile gauze/in alcohol packet. Do not allow it to touch anything considered unsterile. Wear disposable gloves.

7. Crimp with your fingers or clamp the catheter tubing so urine does not flow.

8. Disconnect catheter tubing from drainage bag. Apply cap over end of tubing if reusing that drainage bag.

9. Connect leg bag to the catheter.

10. Unclamp catheter. Check to see that urine is flowing (may take a few minutes).

11. If placing a leg bag or applying new tape, allow enough slack so there is no pull on the catheter.

12. If drainage bag is to be reapplied later, remove the cap, swab the end with alcohol, and replace cap.

C. Steps ending procedure

13-16. See steps 13-16 of catheter care procedure.

SUMMARY AND CONCLUSION:

1. Class discussion items.

2. Review steps of procedures.

LESSON PLAN: 44

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

CLASSROOM DISCUSSION:

1. What kind of things do you always check for when working with the catheter and drainage system?
2. What part of the body do you wash first when doing catheter care?
3. How many inches of the catheter tubing outward is cleaned?
4. Why would a client want to use a leg bag?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates catheter care and application of new bag or leg bag.
2. Students practice catheter care and application of new bag or leg bag.

LESSON PLAN: 44

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS: NAME OF STUDENT: ____________

CATHETER CARE

EQUIPMENT

1. Chase doll (if available)
2. Basin - 1/2 full of warm water
3. Washcloths (2)
4. Mild soap
5. Disposable or reusable bed protector
6. Towel
7. Bath blanket

DID THE STUDENT	YES	NO
Catheter Care		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client Identify self.		
4. Explain the procedure to the client.		
5. Provide privacy.		
B. Catheter care procedure		
6. Client should be in supine position with legs apart; place bed protector under buttocks and between legs.		
7. Cover client with bath blanket, then remove top sheet.		
8. Check catheter and drainage bag for leaks, kinks, level of bag, character of urine, and that it is securely attached to bed frame.		

		YES	NO
9.	Wearing disposable gloves, expose the perineal area.		
a.	Separate the labia of the female client and gently wash around the opening of the urethra with soap and warm water.		
b.	Gently pull back the foreskin of the male client and gently wash around the opening with soap and warm water.		
10.	Wash the catheter from the opening of the urethra outward four inches. Do not pull on the catheter.		
11.	Using a fresh washcloth continue washing, rinsing, and drying the perineal area.		
12.	Remove bed protector and bath blanket.		
C.	Steps ending procedure		
13.	Remove, clean, and store equipment.		
14.	Wash hands.		
15.	Make the client comfortable; place call signal within reach.		
16.	Record observations and report anything unusual to charge nurse.		
	Changing the Drainage Bag		
A.	Steps beginning procedure		
1-5.	Complete steps 1-5 of catheter care procedure.		
B.	Changing the bag procedure		
6.	If applying a reusable leg bag, swab the end to be connected with alcohol and place on sterile gauze/in alcohol packet without allowing it to touch anything considered unsterile.		
7.	Crimp with fingers or clamp the catheter tubing so urine does not flow.		

		YES	NO
8.	Disconnect catheter tubing from drainage bag. Apply cap over end of tubing if reusing that drainage bag.		
9.	Connect leg bag to the catheter		
10.	Unclamp catheter. Check to see that urine is flowing (may take a few minutes).		
11.	If placing a leg bag or applying new tape allow enough slack so there is no pull on the catheter.		
12.	If drainage bag is to be reapplied later, remove the cap, swab the end with alcohol, and replace cap.		
C.	Steps ending procedure 13-16. Complete steps 13-16 of catheter care procedure.		

The student has satisfactorily completed the procedure "CATHETER CARE" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 45

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: VII-45 or DEMONSTRATION

ELIMINATION OF STOOL
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. List four factors which maintain normal bowel function.
3. Describe the characteristics of normal stool.
4. Identify four conditions that may cause abnormal bowel function.
5. List five factors that can lead to constipation.
6. Identify two special measures for abnormal bowel function.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #34: "Bowel Elimination"
2. Projector

TEACHER RESOURCES:

INTRODUCTION:

Elimination of stool is another one of the body's basic functions. Food is taken in, digested and whatever is not needed by the body is eliminated as waste through defecation. There are some basic factors that keep the bowels functioning properly. The nurse assistant must keep these factors in mind because many client's have problems with their bowels, and oftentimes their long-time habits have been interrupted. Normal bowel function is necessary for the client's comfort.

LESSON PLAN: 45

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

OUTLINE: (Key Points)

I. Terms and Definitions

- A. Constipation - the passage of unusually dry, hard stools
- B. Defecation - pass feces from the body
- C. Diarrhea - frequent passage of liquid stool
- D. Distention - the state of being inflated or enlarged
- E. Feces - waste products in the bowel, same as stool and BM
- F. Flatus - gas in the bowel
- G. Impaction - hard stool that cannot pass from the rectum normally
- H. Peristalsis - wave-like movements of the digestive tract which push food along the tract
- I. Suppository - a semisolid substance that may contain medicine that can be inserted into the rectum or vagina where it dissolves.

II. Normal Bowel Elimination

- A. Factors which maintain bowel elimination (CD-1)
    - 1. Diet containing fiber
        - a. Fiber holds water in the wastes in the colon, makes the stool softer
        - b. Fibrous foods are slightly irritating to the bowel, moves wastes along more rapidly
        - c. Nursing responsibilities - encourage foods high in fiber to help prevent constipation
            - 1) Fresh fruits
            - 2) Fresh vegetables

            3) Prunes

            4) Bran

    2. Fluids

        a. Fluids make the stool softer and increase the bulkiness of the stool.

        b. Nursing responsibilities

            1) Provide between 2,000-3,000 ml of fluids per 24 hrs.

            2) Maintain I&O record.

    3. Activity

        a. Physical activity produces a "massaging" action of the abdominal muscles to the intestines, promoting peristalsis

        b. Nursing responsibilities

            1) Encourage ambulation, if possible.

            2) If client is on bedrest or confined to a w/c, encourage active ADL, ROM, position change every two hours.

    4. Habit

        a. Each individual defecates at a certain time of day, sometimes more easily after eating or drinking certain foods or fluids.

        b. Usually has more success if privacy is offered (CD-2)

        c. Nursing responsibilities

            1) Find out from client or family member past bowel habits: how often; time of day; any routine assistance from suppositories/enemas/medications

            2) Provide privacy and try to maintain past habits

B. Stool Characteristics

    1. Color - light to dark brown

2. Consistency - soft and formed

3. Amount - 1/2 to 2 cups

4. Odor - varies with diet and person

5. Frequency - 3 times/day to every other day; varies with each individual

III. Conditions That Cause Abnormal Bowel Function

A. Constipation - passage of unusually dry, hard stools

1. When stool is in rectum for too long water will be absorbed from it. (CD-3)

2. Factors that can lead to constipation

a. Bedrest - inactivity and difficulty in using bedpan due to position; it is difficult to pass stool with legs straight out, rather than squatting position

b. Inadequate fluid intake - fluid that is in stool is absorbedby the bowel

c. Lack of fibrous food in diet

d. General lack of or limited activity

e. Unable to defecate at usual time, place or without privacy

f. Medications can cause constipation; example: codeine

g. Depression - entire body slowed down

B. Impaction - hard mass of stool forms in the bowel that cannot be passed normally

1. Liquid stool passes around the blockage

2. May also note: stool incontinence, pain, discomfort, and abdominal distention

3. Enema may be given to assist in removal or may be removed by digital exam by a licensed nurse.

C. Diarrhea - frequent passage of liquid stools

1. Note color, consistency, amount and frequency of stool. Report to charge nurse.

2. Encourage p.o. fluids if not vomiting, preferably clear liquids.

3. Keep perineal area clean and dry.

D. Hemorrhoids - a varicose vein in the rectum, which may protrude from the anus and be very tender and may bleed from irritation (CD-4)

   1. Caused from straining when passing stool/flatus over a long period of time.

   2. Lay term is "piles".

   3. Note client complaint of pain, itching; blood on outside of stool; report to charge nurse

E. Bowel obstruction - a blockage in the bowel, stool cannot pass through

   1. May be caused from twisting of bowel, tumor, or large impaction of stool

   2. Note client complaint of pain; abdominal distention; no passing of stool for several days; report to charge nurse

F. Bowel incontinence - inability to stop or control passage of stool

   1. Factors that can lead to bowel incontinence

      a. Confusion - unable to understand where/when he/she is passing stool

      b. Sphincter muscle weakness allows stool to pass

      c. Damage to nervous system may prevent message from getting to brain of resident feeling urge.

G. Limited mobility and lack of assistance in getting to the bathroom - client has a problem with meeting normal need to defecate because he/she can hold stool if taken to bathroom as soon as he/she feels the urge

TEACHERS RESOURCES:

INTRODUCTION:

Incontinence of urine or stool is the main reason for starting a client on a retraining program. It is a very embarrassing occurrence. You can imagine how you would feel if this happened to you. A consistent training program can help the client gain control of his/her bowel and/or bladder function. This lesson will help you to understand which clients may be more successful with such a program, how we can retrain them to control their bladder and/or bowels again and how to deal with chronic incontinence.

IV. Special Measures for Abnormal Bowel Function

A. These measures must be ordered by the physician

1. Nonmedicinal suppositories - usually made of glycerine or cocoa butter; may be inserted by the nurse assistant if facility policy allows.

2. Laxatives - medications taken by mouth or in suppository form to increase peristalsis and emptying of the bowel; administered by a licensed nurse (CD-5)

3. Enema - injection of fluid into the rectum to remove stool. In some facilities this procedure is performed by a licensed nurse.

a. Cleansing enema - eliminates stool/flatus; relieves constipation or fecal impaction

1) Tap water - 1,000 cc is usual amount

2) Salt water - 2 tsp. salt in 1,000 cc water

3) Soapsuds - 1 package enema soap in 1,000 cc water (rarely used today)

4) Ready-to-use - Fleet's approx. 4 1/2 oz.

b. Oil retention enema - softens stool, lubricates lower intestines, and prevents straining

1) Must be retained for 10-20 minutes to be effective

2) Usually followed SSE 20 minutes after it has been expelled

V. Summary and Conclusion

A. Terms and definitions

B. Normal bowel elimination

C. Abnormal bowel function

D. Special measures for abnormal bowel function

The elimination of stool is usually a daily occurrence for each client. This body process includes factors that one cannot control--the odor and/or appearance of his/her stool.

Remember to respect his/her privacy and not embarrass the client by your comments or actions. Also remember the nursing measures to promote proper bowel functioning. It is vital for the comfort of your clients.

LESSON PLAN: 45

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

CLASSROOM DISCUSSION:

1. What kind of things do you do to maintain regular bowel habits?

2. How important is trying to provide privacy when someone is defecating?

3. What are some factors that may lead to constipation?

4. What is your client referring to if he/she complains about "piles?"

5. Why does the nurse assistant not administer laxatives? Who administers laxatives?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.

2. Have students discuss their own feelings about defecation and have students who have had to have their elimination needs taken care of by someone else tell of their feelings.

LESSON PLAN: 45

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_____	1.	Constipation	a.	State of being inflated
_____	2.	Defecation	b.	Pass feces from the body
_____	3.	Diarrhea	c.	Hard stool that cannot pass from the rectum normally
_____	4.	Distension	d.	Frequent passage of liquid stool
_____	5.	Feces	e.	Gas in the bowel
_____	6.	Flatus	f.	Waste products in the bowel
_____	7.	Impaction	g.	Passage of unusually dry, hard stool
_____	8.	Peristalsis	h.	Wave-like movement of bowel that pushes stool along the intestinal tract

9. List four factors which help a client maintain normal bowel functions.

   a.

   b.

   c.

10. What are the normal characteristics of stool?

   a. Color:

   b. Consistency:

   c. Amount:

   d. Odor:

   e. Frequency:

11. List five factors that could lead to constipation.

a.

b.

c.

d.

e.

12. Which of the following is not a special measure for abnormal bowel function? (Circle the letter of the correct answer.)

a. Non-medicinal suppository
b. Enema
c. Laxative
d. Analgesic

13. Which of the following is not a condition that can cause abnormal bowel function? (Circle the letter of the correct answer.).

a. Hemorrhoids
b. Impaction
c. Bowel obstruction
d. Bladder infection
e. Diarrhea

LESSON PLAN: 45

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

ANSWERS TO EVALUATION ITEMS:

1. g

2. b

3. d

4. a

5. f

6. e.

7. c

8. h

9.
   a. Diet containing fiber
   b. Fluids
   c. Activiy
   d. Habit

10.
   a. Color: light to dark brown
   b. Consistency: soft and formed
   c. Amount: 1/2 to 2 cups
   d. Odor: varies with diet and person
   e. Frequency: 3 times/day to every other day, varies with each individual

11. The student may list any five of the following:

   a. Constipation
   b. Impaction
   c. Diarrhea
   d. Hemorrhoids
   e. Bowel obstruction
   f. Bowel incontinence

12. d

13. d

LESSON PLAN: 46

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: VII-46 or DEMONSTRATION

BLADDER AND BOWEL RETRAINING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms presented in this lesson.
2. Recognize key concepts of a bladder retraining program.
3. Identify responsibilities of the nurse assistant in a bladder retraining program.
4. Identify responsibilities of the nurse assistant in a habit training program for clients with chronic incontinence.
5. Identify responsibilities of the nurse assistant in a bowel training program.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #401: "Bowel and Bladder Training"
2. Projector

LESSON PLAN: 46

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

OUTLINE: (Key Points)

I. Terms and Definitions

    A. Acute - rapid onset, short-term

    B. Chronic - long, drawn out, long-term

    C. Nocturia - to urinate during the night

II. Bladder Retraining Program (CD-1)

    A. For the client who has adequate mental and/or physical function to be retrained with an order from the physician

        1. A client who has had a catheter inserted during an acute illness

        2. Recent urinary tract infection

        3. Stroke

    B. Key concepts

        1. The client is given a measured amount of fluid regularly throughout the day and placed on a bedpan/bedside commode/or taken to the bathroom toilet to empty his/her bladder at specific times throughout the day and night.

        2. This program will help the client by strengthening the bladder and sphincter muscles and training the bladder control center in the brain to expect a regular pattern of urination.

        3. A retraining program may be used for the client who still has a catheter. The catheter is clamped and opened for certain lengths of time. A schedule should be written by the charge nurse and followed by the nursing staff. The bladder retraining program will be continued after the catheter is removed until control of urinary function is regained.

    C. Nurse assistant responsibilities

1. Providing adequate fluid intake is a must! It is needed to keep the urine diluted.
    a. A schedule of fluid intake should be set up by the charge nurse that the client and staff can follow.
    b. You may need to remind the client to drink.
    c. Keep an accurate I&O record.
    d. Most fluids should be taken in between 7 a.m. and 7 p.m. to prevent nocturia.
2. A voiding schedule should be established and adhered to. (CD-2, 3)
    a. You must observe and record the client's usual pattern for a few days to determine a schedule; adequate fluid intake should be provided for during this time.
    b. If the client cannot stay dry for at least two hours, then he/she needs to be taken to the bathroom every two hours.
    c. If the client is dry for 3 to 4 hours, then taking him/her upon awakening in a.m., before and after meals, and at bedtime may be sufficient.
    d. If the client is independent and able to tell you, answer the calls promptly or offer your assistance at the usual times he/she voids.
    e. Measure and record urinary output.
    f. The client will need to be awakened during the night and assisted to the toilet if he/she usually voids during that time.
3. Client can void easier in an upright position; standing for men and sitting for women.
4. If the client is incontinent at times, keep him/her clean and dry; never scold the client if unsuccessful.
5. Involve the client; explain the bladder control program to the client. If a client can accomplish this, it will help him/her to feel more confident, independent and increase his/her self-esteem.

III. Habit Training Program for Chronic Incontinence (CD-4)

A. Clients who suffer from chronic bladder incontinence should be placed on a scheduled voiding or habit training program to keep him/her dry.

1. Clients who have severe weakness of bladder and sphincter muscles
2. Diseases/injuries causing brain damage of area that controls bladder function
3. Enlarged prostrate gland in males

B. Nurse assistant responsibilities

1. Observe and record the client's usual times for voiding for a few days to determine his/her pattern.
2. Set up a toileting schedule from observations to check client for incontinence.
3. Encourage p.o. liquids and record intake.
4. Remove incontinent briefs/pads and give good peri care. Apply fresh incontinent pads or briefs (according to manufacturer's or facilities directions).
5. Observe the skin for any signs of breakdown--redness, irritation, sores, etc.
6. Treat the client with respect; be understanding.

IV. Bowel Training Program

A. A program set up to assist the client to eliminate at his/her usual time of day and to prevent incontinence of stool.

B. Nurse assistant responsibilities (CD-5)

1. Observe and record client's usual pattern of bowel movements; include time of day (a.m./p.m.) and how often, for a week.
2. Assist client to bathroom toilet/bedside commode/ bedpan at time of day that he/she usually defecates. Provide as much privacy as possible, allow plenty of time for client to finish, and assure a sitting position as much as possible.

3. Encourage adequate fluid intake and proper diet.

4. Encourage regular exercise. (CD-6)

5. Suppositories may be ordered by the physician as part of the training program to promote a regular elimination pattern

    a. The nurse assistant may insert a suppository that does not contain any medicine.

    b. It must be inserted along the wall of the rectum and never into feces.

    c. The suppository has to be absorbed by the blood vessels in the walls of the bowel to cause the bowel to contract and expel the feces.

6. Note time of elimination and character of stool. Report any changes in schedule to the charge nurse

7. Be patient and understanding. If the client can accomplish this, it will help him/her to feel more confident, independent, and will increase his/her self-esteem.

8. If a client is unsuccessful with the program, follow the nurse assistant responsibilities for habit training program for chronic incontinence (see III. B. 1 through 6.) (CD-7)

IV. Summary and Conclusion

A. Terms and definitions

B. Bladder training program

C. Habit training program for chronic incontinence

D. Bowel training program

The retraining of the bladder and bowels can be accomplished. It requires your time and patience. It can be frustrating if the client is not making progress, but we must keep a positive attitude for the client's sake throughout the scheduled program. It also can be very satisfying and rewarding to know that you have helped someone feel good about himself/herself by gaining confidence and control in this area.

LESSON PLAN: 46

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS:

Define the following terms.

1. Nocturia -

2. Chronic -

3. Acute -

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 4. The bladder and sphincter muscles are strengthened when the client is on a bladder training program.

_____ 5. A client with a catheter should not be started on a program until the catheter has been removed.

_____ 6. Fluids should be restricted if the client is incontinent of urine.

_____ 7. The nurse assistant should wait until the client asks to go to the bathroom when he/she is on a bladder training program.

_____ 8. The position of a client when trying to void is not important.

_____ 9. The incontinent client must be kept clean and dry to prevent skin breakdown.

_____10. The client should be left alone at night and not gotten up to go to the bathroom.

_____11. Providing privacy and allowing plenty of time to defecate are important to the client.

_____12. Exercise helps the client to control the bowel.

_____13. Suppositories may be ordered by the physician to help with bowel training.

_____14. Ambulatory clients should use the bathroom toilet when they are on a bowel training program.

_____15. Clients who are incontinent should be scolded.

_____16. Bowel and bladder training helps the client to become more independent.

LESSON PLAN: 46

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

CLASSROOM DISCUSSION:

1. What type of client could be successful with a bladder training program?

2. Should a client who has just had a catheter removed and stays dry for only an hour be considered for retraining?

3. What kind of observations do you need to make prior to setting up a voiding schedule?

5. What kind of observations do you need to make prior to setting up a bowel training program?

6. What types of things may be used to stimulate the client to defecate at certain times?

7. Should a client be reprimanded when he/she is incontinent?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip and discuss it.

2. Assign students to care for clients on bowel and bladder training programs.

LESSON PLAN: 47

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

CLASSROOM DISCUSSION:

1. What can you do to warm a bedpan?
2. What can you do to prevent a client's skin from sticking to the bedpan?
3. Why would you use a fracture pan?
4. Why is it important to thoroughly clean a bedpan/urinal before storing it?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates how to place a bedpan for a client who can help and one who cannot.
2. Students practice giving a bedpan to one another, simulating a client who can help and one who cannot help.

LESSON PLAN: 46

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

ANSWERS TO EVALUATION ITEMS:

1. Nocturia - to urinate during the night
2. Chronic - long, drawn out, long-term
3. Acute - rapid onset, short term
4. T
5. F
6. T
7. F
8. F
9. T
10. F
11. T
12. T
le. T
lr. T
15. F
16. T

LESSON PLAN: 47

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: or DEMONSTRATION VII-47

GIVE AND REMOVE URINAL AND BEDPAN
(Lesson Title)

LESSON OBJECTIVES THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to place and remove a urinal according to the steps of procedure.
2. Demonstrate how to give and remove a bedpan according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Urinal and Bedpans
2. Urinal and cover
3. Regular bedpan and cover
4. Fracture pan and cover

TEACHER RESOURCES:

INTRODUCTION:

Clients who are unable to get out of bed to use a portable bedside commode or go to the bathroom toilet, must use a urinal or bedpan. The urinal is a container into which the male client urinates; he must use a bedpan if he needs to defecate. The female client must use a bedpan for urination and defecation. Remember how important it is to keep this equipment clean to prevent the spread of infection, and that it is to be used only by the client to whom it belongs. Always empty urinals/bedpans into toilets or hoppers--never into a sink.

LESSON PLAN: 47

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

STEPS OF PROCEDURE:

A. Steps beginning procedure

1. Wash your hands
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Put on disposable gloves

B. Urinal procedure

7. Turn back top bedding, except for top sheet. Expose the peri area.
8. Place the client's penis in the urinal and lay the urinal between his legs.
9. Make sure urinal is placed at an angle to keep urine from spilling out. Flat bottom should lie on bed.
10. Wash your hands
11. Place signal cord within reach and leave the room.
12. Return to room promptly when client signals.
13. Remove and cover urinal and take to the bathroom.

C. Steps ending procedure

14. Measure urine if on I&O and empty into toilet.
15. Clean and store equipment.
16. Wash your hands.
17. Give client a wet washcloth to wash his hands. Make client comfortable and place signal cord within reach.

18. Record observations.

NOTE: Report anything unusual to charge nurse.

Give and Remove a Bedpan with Client Assisting

A. Steps beginning procedure

1-6. See steps 1-6 of give and remove urinal procedure.

B. Client who can assist procedure

7. Client should be in supine position; turn back top bedding.

NOTE: Sprinkle powder on bedpan to prevent (CD-2) sticking.
Use fracture pan when:
  Client cannot elevate hip.
  Client must use bedpan frequently.
  Client is small or thin.

8. Have client flex his/her knees and lift buttocks off mattress. Assist by slipping hand under the lower part of his/her back. If client has pajama bottom or underwear on, lower it to his/her knees.

9. With your other hand, slip the bedpan under the client's hips and adjust.

10. Raise the head of bed and side rails for client's comfort and safety. Place toilet tissue and signal cord within reach.

11. Wash your hands and leave the room.

12. Return to room promptly when the client signals or check on him/her after five minutes.

NOTE: Do not leave client on bedpan over ten minutes--may lead to extreme discomfort and result in skin breakdown.

13. Lower the head of bed and side rail of side you are on.

14. Place on hand under the small of the back and assist him/her to lift his/her hips.

15. Remove bedpan with other hand and then cover it.

C. Steps ending procedure

16. Wipe, wash and dry the perineal area from front to back.

17. Take bedpan to bathroom; measure urine if on I&O, and empty into toilet.

18. Clean and store equipment. (CD-4)

19. Wash your hands.

20. Give client a wet washcloth to wash his/her hands, make client comfortable and place signal cord within reach.

21. Record observations.

NOTE: Report anything unusual to charge nurse.

Give and Remove a Bedpan for the Helpless Client

A. Steps beginning procedure

1-6. See steps 1-6 of give and remove urinal procedure.

B. Client who cannot assist procedure

7. Client should be in supine position. Turn back top bedding except for top sheet; side rail of the side you are not working from should be up.

8. Turn client on his/her side away from you.

9. Expose buttocks and position bedpan firmly against buttocks.

10. Place small pillow/rolled towel at top of bedpan at the small of the client's back.

11. Turn client toward you and onto the bedpan.

12. Raise the head of the bed if allowed; put side rail up. Place signal cord within reach.

13. Wash your hands and leave the room.

14. Return to room promptly when the client signals or check on him/her after five minutes.

15. Lower the head of bed and the side rail of side you are on.

16. Hold bedpan with one hand and roll client off pan with other hand. This will prevent contents from spilling. Remove bedpan and cover it.

C. Steps ending procedure

17-21. See steps 16-21 of give and remove bedpan with client assisting procedure.

SUMMARY AND CONCLUSION:

1. Classroom discussion items.

2. Review steps of procedures.

LESSON PLAN: 47

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS: NAME OF STUDENT: ____________________

GIVE AND REMOVE URINAL AND BEDPAN

EQUIPMENT

1. Urinal and cover
2. Bedpan and cover

DID THE STUDENT	YES	NO
Give and Removal Urinal		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client Identify self.		
4. Explain the procedure to the client.		
5. Provide privacy.		
6. Put on gloves.		
B. Urinal procedure		
7. Turn back top bedding, except for top sheet. Expose the peri area.		
8. Place the client's penis in the urinal and lay the urinal between his legs.		
9. Make sure urinal is placed at an angle. Flat edge should be lying on bed.		
10. Wash hands.		
11. Place signal cord within reach and leave the room.		
12. Return to room promptly when client signals.		
13. Remove and cover urinal and take to the bathroom		

C. Steps ending procedure

14. Measure urine if on I&O and empty into toilet

15. Clean and store equipment.

16. Wash hands

17. Give client a wet washcloth to wash his hands. Make client comfortable and place signal cord within reach.

18. Record observations and report anything unusual to charge nurse.

Give and Remove a Bedpan With Client Assisting

A. Steps beginning procedure

1-6 Complete steps 1-6 of give and remove urinal procedure.

B. Client who can assist procedure

7. Client should be in supine position; turn back top bedding

NOTE: Sprinkle powder on bedpan to prevent sticking.

8. Have client flex his/her knees and lift buttocks off mattress, assist by slipping hand under the lower part of his/her back. If client has pajama bottoms or underwear on, lower it to his/her knees.

9. With other hand, slip the bedpan under the client's hips and adjust.

10. Raise the head of bed and side rails for client's comfort and safety. Place toilet tissue and signal cord within reach.

DID THE STUDENT	YES	NO
11. Wash hands and leave the room		
12. Return to room promptly when the client signals or check on him/her after five minutes.		
13. Lower the head of bed and side rail of side nurse assistant is on.		
14. Place one hand under the small of the back and assist client to lift hips.		
15. Remove bedpan with other hand and then cover it.		
C. Steps ending procedure		
16. Wipe, wash and dry the perineal area from front to back.		
17. Take bedpan to bathroom; measure urine if on I&O, and empty into toilet.		
18. Clean and store equipment.		
19. Wash hands.		
20. Give client a wet washcloth to wash his/her hands, make client comfortable and place signal cord within reach.		
21. Record observations and report anything unusual to charge nurse.		
Give and Remove a Bedpan for the Helpless Client		
A. Steps beginning procedure		
1-6 Complete steps 1 6 of give and remove urinal procedure.		
B. Client who cannot assist procedure.		

DID THE STUDENT		YES	NO
7.	Client should be in supine position, turn back top bedding except for top sheet; side rail of side assistant is not working from should be up.		
8.	Turn client on his/her side away from assistant.		
9.	Expose buttocks and position bedpan firmly against buttocks.		
10.	Place small pillow/rolled towel at top of bedpan at the small of the client's back.		
11.	Turn client towards assistant and onto the bedpan.		
12.	Raise the head of the bed if allowed; side rail up. Place signal cord within reach.		
13.	Wash hands and leave the room.		
14.	Return to room promptly when the client signals or check on him/her after five minutes.		
15.	Lower the head of bed and side rail of side assistant is on.		
16.	Hold bedpan with one hand and roll client off pan with other hand. Remove bedpan and cover it.		
C.	Steps ending procedure		
17-21.	Complete steps 16-21 of give and remove bedpan with client assisting procedure.		

The student has satisfactorily completed the procedure "GIVE AND REMOVE URINAL AND BEDPAN" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 48

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: or DEMONSTRATION VII-47

ADMINISTER AN ENEMA
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate knowledge of how to administer an enema according to steps of procedure.

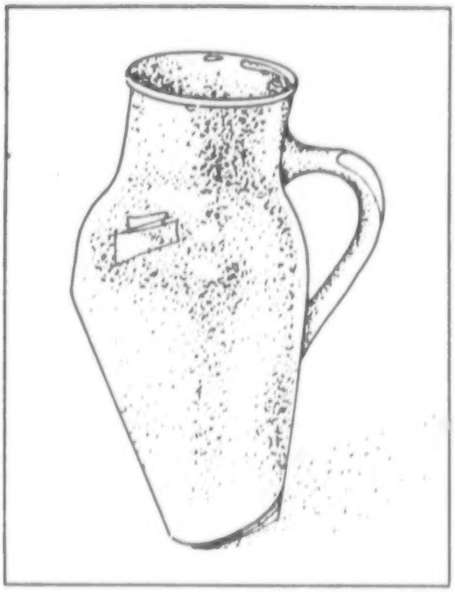
SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Administering an Enema
2. Enema bag/bucket or ready-to-use enema
3. Enema soap (if applicable)
4. Bedpan and toilet tissue
5. Tap water - 105 degrees Fahrenheit
6. Disposable/reusable bed protector
7. Water soluble lubricant
8. IV Pole to hang bag
9. Paper towel

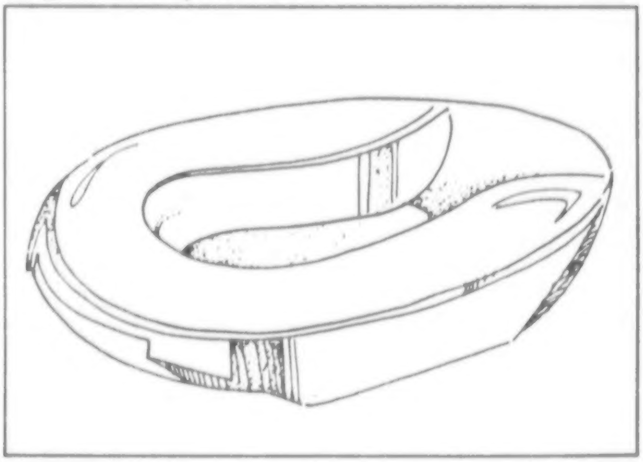
URINAL AND BED PANS

HO 1

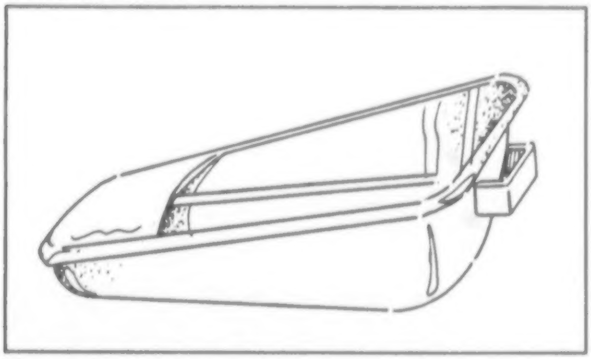
Urinal



Regular Bedpan



Fracture Pan



Used for thin or disabled residents
who do not have large stools.

9. Brush or comb hair gently using downward strokes starting at ends first, working toward the scalp.

   NOTE: Add a few drops of water/alcohol to hair to remove tangles.

10. Arrange hair attractively to the client's satisfaction. Braiding is suggested for the client with long hair. This prevents tangling.

11. Let client use the hand mirror.

C. Steps ending procedure

12-15. See III. C., steps 22-25 of shampoo with tub bath or shower bath procedure.

VI. Summary and Conclusion

A. Key point of hair care.

B. Specific measures related to hair care.

C. Classroom discussion.

D. Review steps of procedures.

TEACHER RESOURCES:

INTRODUCTION:

The body eliminates wastes, such as urine, stool and sputum, which can be useful in diagnosing and treating an illness. It is a responsibility of the nurse assistant to obtain these specimens. He/she must be aware of the importance of accuracy when collecting a specimen. Make sure it is the right specimen from the right client at the right time using the right procedure. If you are not absolutely sure of the instructions, check with the charge nurse. A client can be harmed if you make a mistake.

The following procedure covers how to obtain a routine urine, stool, and sputum specimen. A midstream/clean-catch urine specimen is also discussed. This type of specimen is as free of contamination as possbile without inserting a catheter to obtain the specimen.

When a specimen is ordered by the doctor, explain to the client to call you immediately when he/she feels the urge to urinate/defecate/cough so a specimen can be obtain as soon as possible.

LESSON PLAN: 49

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

STEPS OF PROCEDURE:

Routine Urine Specimen

A. Steps beginning procedure

1. Wash your hands
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Put on disposable gloves.

B. Collecting routine urine specimen

7. Wash the client's perineal area if it is soiled, otherwise it is not necessary.
8. Offer a clean bedpan/urinal/or assist to bedside commode, or toilet fitted with speci pan.
9. Ask client to void.

   NOTE: Explain need to dispose of first few drops.

   NOTE: Instruct client not to put toilet paper or pass stool in receptacle used to collect urine.

10. Have client wash hands, if client collected specimen.
11. Take covered bedpan/urinal to the client's bathroom or dirty utility room.
12. If client is on output, note amount of urine voided and record on I&O.
13. Carefully pour urine into specimen container, fill it 3/4 full, if possible.
14. Cover container tightly and securely. Apply label.

TEACHER RESOURCES:

INTRODUCTION:

Some clients cannot eliminate stool in a natural manner and need some help. We can provide help by administering enemas. The type of enema will be determined by the instruction received from the charge nurse. There are several types of enemas that can be given, such as cleansing or oil-retension. The procedure is basically the same for each type. Never give an enema in a sitting position because the solution cannot flow into the bowel.

LESSON PLAN: 48

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

STEPS OF PROCEDURE: (Demonstration Only) (No return demonstration)

Administer an Enema (HO-1)

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy
6. Have client empty the bladder; assist with bedpan/bedside commode.

Enema procedure

7. Client should be in bed, head of bed flat if tolerated; cover client with bath blanket and turn down top bedding.
8. Place bed protector under buttocks; assist or turn client to left side with knees flexed, if possible.

   NOTE: Left side promotes flow of solution into large intestine.
9. Place bedpan at foot of bed or bedside commode near bed if client can't go to bathroom toilet.
10. Clamp enema tubing; fill enema bag with amount of solution ordered by physician.

    NOTE: Usual amount is 1,000 cc's of 105 degrees Fahrenheit water.
11. a. If giving a soapsuds enema, empty liquid soap into filled container and agitate gently to distribute soap.

    NOTE: Do not make suds because this will put air into the client's bowel.

   b. If giving a saline enema, add salt and agitate gently.

12. Expel air from tubing by allowing small amount of solution to flow into bedpan/bedside commode, then clamp/pinch tubing a few inches from tip.

13. Put about a teaspoon of lubricant on a piece of toilet tissue. Rub lubricant on lower three inches of tube.

14. Wearing disposable gloves; put them on now.

15. Raise client's upper buttock to expose anus.

16. Ask client to take a deep breath while you insert tip of rectal tube. Rotate tip slowly as you insert it about three inches. If you feel resistance or if the client complains of pain, remove tube; cover client and notify charge nurse.

17. Release lifted buttock and unclamp tubing. Hold bag or place it so that the level of the solution is never higher than 12 inches above the anus.

18. Adjust flow of solution for client's comfort--lower the bag if client complains of cramping.

19. Have client take deep breaths through his/her mouth to relax him/her.

20. If client has severe cramps or pain that does not pass, or if he/she starts perspiring heavily or feels faint, discontinue enema and notify charge nurse.

21. If client has trouble holding solution, stop the flow for a few minutes and then start again.

22. Clamp tube when solution is taken and remove tube, rotate it slowly and gently as you pull it out. Wrap in paper towel or put it in the container.

23. Ask client to retain solution as long as possible. You can assist by applying slight pressure over anal region by holding/pressing buttocks together.

24. Assist client to retain solution as long as possible. You can assist by applying slight pressure over anal region by holding/pressing buttocks together.

25. Place call signal and toilet tissue within reach.

26. Wash your hands and leave the room, unless assistance is needed because of clients age or condition.

27. Check on resident after five minutes or before if he/she signals.

28. When finished, remove bedpan and observe results--note characteristics of stool.

29. Clean client with wet washcloth and dry peri area thoroughly.

Steps ending procedure

30. Remove, clean and store equipment.

31. Wash your hands.

32. Record observations.

NOTE: Report anything unusual to charge nurse.

SUMMARY AND CONCLUSION

1. Ask interaction items.

2. Review steps of procedure.

LESSON PLAN: 48

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

CLASSROOM DISCUSSION:

1. What is the temperature of the enema solution for a soapsuds enema?
2. When an enema is given, the client should be in what position?
3. What should you do if the client complains of pain and/or cramping?
4. What should you do if the client feels faint or starts perspiring heavily?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates setting up equipment and giving an enema using Chase doll or client.

LESSON PLAN: 48

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

__________ 1. The client should be in bed, lying on the right side.

__________ 2. The usual amount of fluid is 1,000 cc of fluid of 105 degrees Fahrenheit water.

__________ 3. Shake the solution and soap suds for a more effective enema.

__________ 4. Hold enema bag so that level of solution is never higher than 12 inches above the anus.

__________ 5. If the client has severe cramps or pain that does not pass, discontinue enema and notify nurse.

__________ 6. Instruct client to take deep breaths through his/her mouth to relax him/her.

__________ 7. The client may expel the enema solution immediately after it is given.

__________ 8. Check on client after 20 minutes or before he/she signals.

LESSON PLAN: 48

COURSE TITLE: NURSE ASSISTANT

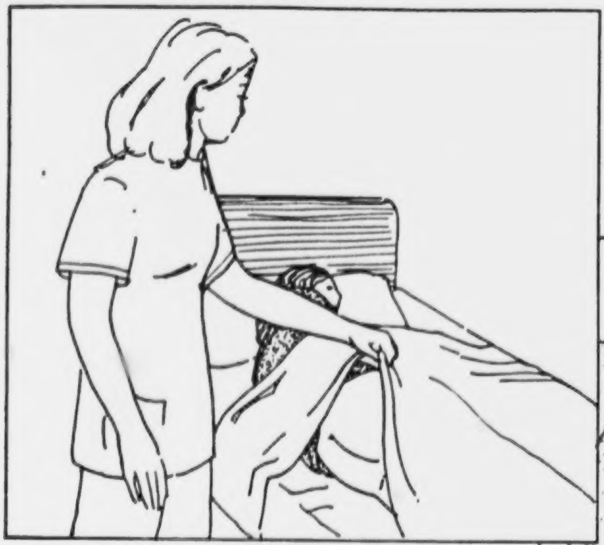
UNIT VII: ELIMINATION

ANSWERS TO EVALUATION:

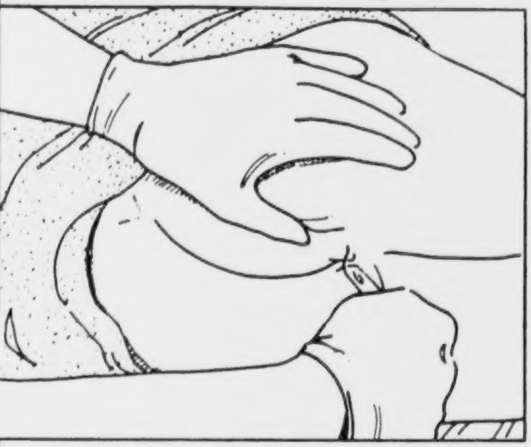
1. F
2. T
3. F
4. T
5. T
6. T
7. F
8. F

ADMINISTERING AN ENEMA

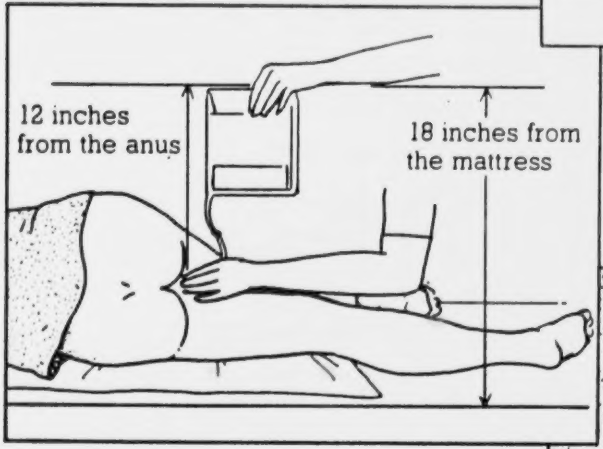
1. Positioning of Resident



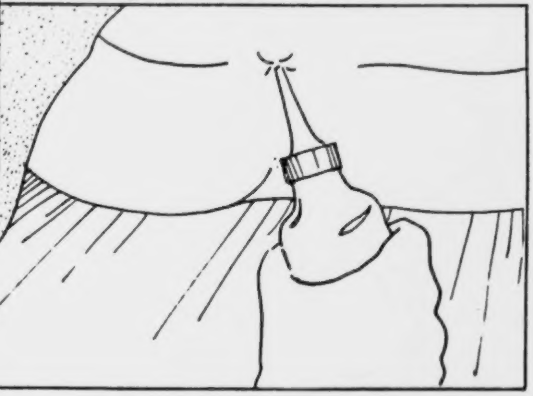
2. Inserting Enema Tubing



3. Level of Enema Bag


12 inches
from the anus
18 inches from
the mattress

4. Ready-To-Use Enema



LESSON PLAN: 49

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: or DEMONSTRATION VII-49

SPECIMEN COLLECTION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to obtain a routine urine specimen according to the steps of procedure.
2. Demonstrate how to obtain a clean-catch/midstream urine specimen according to the steps of procedure.
3. Demonstrate how to obtain a urine specimen from a closed urinary drainage system according to the steps of procedure.
4. Demonstrate how to obtain a stool specimen according to the steps of the procedure.
5. Demonstrate how to obtain a sputum specimen according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #339: "Collecting Urine Specimens" (stool specimen)
2. Projector
3. Bedpan/urinal
4. Specimen container
5. Specimen label

6. Lab requisition slip
7. Tongue depressor
8. Alcohol sponge (catheter specimen)
9. Syringe with attached needle (catheter specimen)
10. Sterile specimen container (midstream urine specimen)
11. Antiseptic solution
12. Cotton balls
13. Discard container
14. Soap and water
15. Washcloth
16. Towel
17. Disposable gloves

	YES	NO
B. Collecting midstream/clean catch urine specimen		
7. Clean peri area with soap and water if soiled.		
8. Apply antiseptic solution to cotton balls and put on disposable gloves.		
9. a. Female client		
1. Spread labia and expose urinary opening.		
2. Using a cotton ball with antiseptic solution on it, wipe from front to back on one side, discard cotton ball.		
3. Wipe from front to back on other side, discard cotton ball.		
4. Then wipe down the center and discard cotton cotton ball.		
b. Male client		
1. Hold penis just down from the head of the penis; retract the foreskin, if uncircumcised		
2. Cleanse the head of the penis and urinary opening with a cotton ball with antiseptic solution on it using a circular motion three times.		
3. Use a cotton ball once and then discard.		
10. Ask client to start to urinate into bedpan/urinal/ toilet.		
11. After flow has started, ask client to stop urinating.		
12. Place specimen container under client and ask him to start urinating again into container.		

	YES	NO
13. If client cannot stop urinating once he/she has started, move container into the stream of urine to collect the middle of the stream specimen directly into container.		
14. Remove container before the flow of urine stops.		
15. Cover container tightly. Apply label.		
16. Pour leftover urine into toilet/hopper.		
C. Steps ending procedure 16-21. Complete steps 16-20 of routine urine specimen procedure.		
Collecting Specimen From Closed Urinary Drainage Sytem A. Steps beginning procedure 1-6. Complete steps 1-6 of routine urine specimen procedure.		
B. Collecting urine specimen from closed drainage system. 7. Close clamp on drainage tubing below the speci-port.		
8. Cleanse the speci-port with the alcohol sponge.		
9. Remove needle cover from syringe.		
10. Insert needle into speci-port and pull gently back on the plunger to obtain required amount of urine.		
11. Remove needle and syringe form speci-port. Cleanse the speci-port with an alcohol sponge.		
12. Open clamp from drainage tubing, check to see that urine is draining into drainage bag.		
13. Place needle of syringe into specimen container and push plunger to expel urine into specimen container.		

	YES	NO
14. Cover container tightly. Apply label.		
15. Take syringe, needle and cover to proper container and dispose of them according to the facility's policy.		
C. Steps ending procedure 16-20. Complete steps 16-20 of routine urine specimen procedure.		
Stool Specimen A. Steps beginning procedure 1-6. Complete steps 1-6 of routine urine specimen procedure.		
7. Assist client onto bedpan/bedside commode or into bathroom toilet fitted with speci-pan.		
8. Ask client not to urinate or put soiled tissue into receptacle.		
9. Have client wash his/her hands if he/she collected the specimen.		
10. Take the covered bedpan to the client's bathroom or to the dirty utility room.		
11. Using the wooden tongue depressor, take about 1 to 2 tablespoons of stool from the bedpan and place it into the specimen container.		
12. Cover specimen container securely. Apply label.		
13. Wrap tongue depressor in a paper towel, break in two, and discard it.		
14. Empty the remaining stool into the toilet/hopper.		

15. Measure leftover urine if client is on I&O, then pour into toilet/hopper.

C. Steps ending procedure

16. Remove, clean, store equipment.

17. Wash your hands

18. Make the client comfortable; place call signal within reach.

19. Inform charge nurse that specimen has been collected; if it is not sent to lab immediately, store according to facility's policy.

20. Record that specimen has been obtained.

Midstream/Clean-Catch Urine Specimen

A. Steps beginning procedure

1-6. See steps 1-6 of routine urine specimen

B. Collecting midstream/clean catch urine specimen

7. Clean peri area with soap and water if soiled.

8. Apply antiseptic solution to cotton balls and put on disposable gloves.

9. a. Female client

    1. Spread labia and expose urinary opening.

    2. Using a cotton ball with antiseptic solution on it, wipe from front to back on one side; discard cotton ball.

    3. Wipe from front to back on other side; discard cotton ball.

    4. Then wipe down the center and discard cotton ball.

   b. Male client

    1. Hold penis just down from the head of the penis; retract the foreskin, if uncircumcised.

    2. Cleanse the head of the penis and urinary opening with a cotton ball with antiseptic solution on it using a circular motion, three times.

    3. Use a cotton ball once and then discard.

10. Ask client to start to urinate into bedpan/urinal/toilet.

11. After flow has started, ask client to stop urinating.

12. Place specimen container under client and ask him/her to start urinating again into container.

    NOTE: Do not allow anything to touch the inside surfaces of the specimen container or lid. This would contaminate the specimen.

13. If client cannot stop urinating once he/she has started, move container into the stream of urine to collect the midstream specimen directly into container.

14. Remove container before the flow of urine stops.

15. Cover container tightly. Apply label.

C. Steps ending procedure

16-20. See steps 16-20 of routine urine specimen procedure.

Collecting Specimen From Closed Urinary Drainage System

A. Steps beginning procedure

1-6. See steps 1-6 of routine urine specimen procedure.

B. Collecting urine specimen from closed drainage system.

7. Close clamp on drainage tubing below the speci-port.

    NOTE: Never leave the bedside at this time without unclamping the tubing.

8. Cleanse the speci-port and pull gently back on the plunger to obtain required amount of urine.

9. Remove needle cover from syringe.

10. Insert needle into speci-port and pull gently back on the plunger to obtain required amount of urine.

11. Remove needle and syringe from speci-port. Cleanse the speci-port with an alcohol sponge.

12. Open clamp from drainage tubing. Check to see that urine is draining into drainage bag.

13. Place needle of syringe into specimen container and push plunger to expel urine into specimen contaner.

14. Cover container tightly. Apply label.

15. Take syringe, needle and cover to proper container and dispose of them according to the facility's policy.

C. Steps ending procedure.

16-20. See steps 16-20 of routine urine specimen procedure.

Stool Specimen

A. Steps beginning procedure

1-6. See steps 1-5 of routine urine specimen

B. Collecting a stool specimen

7. Assist client onto bedpan/bedside commode or to bathroom toilet fitted with speci-pan.

NOTE: Do not allow client to use bathroom toilet.

8. Ask client not to urinate or put toilet tissue into receptacle.

9. Have client wash his/her hands if he/she collected the specimen.

10. Take the covered bedpan to the client's bathroom or to the dirty utility room.

11. Using the wooden tongue depressor, take about 1 to 2 tablespoons of stool from the bedpan and place it into the specimen container.

12. Cover specimen container securely. Apply label.

13. Wrap tongue depressor in a paper towel, break in two, and discard it.

14. Empty the remaining stool into the toilet/hopper.

C. Steps ending procedure

15-19. See steps 16-20 of routine urine specimen procedure.

Sputum Specimen

A. Steps beginning procedure

1-6. See steps 1-6 of routine urine specimen

B. Collecting a sputum specimen

7. If the client has eaten recently, have him/her rinse out his/her mouth.

8. Instruct client to take three deep breaths in a row and on the thrid exhalation to cough deeply from within the lungs to bring up the sputum.

   NOTE: Saliva and nose secretions are not to be used for this test.

9. Client may have to cough several times to bring up enough sputum for the specimen, One to two tablespoons is usually the required amount.

10. Cover specimen container tightly. Apply label.

C. Steps ending procedure

11-15. See steps 16-20 of routine urine specimen procedure.

SUMMARY AND CONCLUSION:

1. Classroom discussion

2. Review steps of procedure

LESSON PLAN: 49

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

CLASSROOM DISCUSSION:

1. What four things should you make sure of when collecting any specimen to ensure accuracy?
2. What is the difference between a routine urine specimen and a midstream and a midstream or clean-catch urine specimen?
3. Why shouldn't the client put toilet paper in the bedpan when collecting a urine/stool specimen?
4. How much urine is needed for a specimen?
5. How much stool is needed for a specimen?
6. How much sputum is needed for a specimen?
7. Why is it important not to touch the inside surfaces of a specimen container?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Shoe filmstrip.
2. Show students all the equipment that is needed to collect specimens.
3. Students obtain various specimens ordered by physician from client during on-the-job training.

LESSON PLAN: 49

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS: NAME OF STUDENT: ____________________

SPECIMEN COLLECTION

EQUIPMENT

1. Bedpan/urinal
2. Specimen container
3. Specimen label
4. Label requisition slip
5. Sterile specien container
6. Antiseptic solution
7. Cotton balls
8. Discard container
9. Tongue depressor
10. Alcohol sponge
11. Syringe with attached needle
12. Soap and water
13. Washcloth
14. Towel
15. Disposable gloves

DID THE STUDENT	YES	NO
Routine Urine Specimen		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client Identify self.		
4. Explain the procedure to the client.		
5. Provide privacy.		
6. Put on disposable gloves.		
B. Collecting routine urine specimen		
7. Wash the client's perineal area if it is soiled, otherwise it is not necessary.		
8. Offer a clean bedpan/urinal/or assist to bedside commode, or toilet fitted with speci-pan.		
9. Ask client to void.		

	YES	NO
10. Have client wash hands, if client collected specimen.		
11. Take covered bedpan/urinal to the client's bathroom or dirty utility room.		
12. If client is on output, note amount of urine voided and record on I&O.		
13. Carefully pour urine into specimen container, fill it 3/4 full, if possible.		
14. Cover container tightly and securely. Apply label.		
15. Measure leftover urine if client is on I&O, then pour into toilet/hopper.		
C. Steps ending procedure 16. Remove, clean, and store equipment.		
17. Wash hands.		
18. Make the client comfortable; place call signal within reach.		
19. Inform charge nurse that specimen has been collected; if it is not sent to lab immediately, store according to facility's policy.		
20. Record that specimen has been obtained.		
Midstream/Clean Catch Urine Specimen A. Steps beginning procedure 1-6. Complete steps 1-6 of routine urine specimen procedure.		

	YES	NO
C. Steps ending procedure		
15-19. Complete steps 16-20 of routine urine specimen procedure.		
Sputum Specimen		
A. Steps beginning procedure		
1-6. Complete steps 1-6 of routine urine specimen procedure.		
7. If the client has eaten recently have him/her rinse out his/her mouth.		
8. Instruct client to take three deep breaths in a row and on the third exhalation to cough deeply from within the lungs to bring up the sputum.		
9. Client may have to cough several times to bring up enough sputum for the specimen.		
10. Cover specimen container tightly. Apply label.		
C. Steps ending procedure		
11-15. Complete steps 16-20 of routine urine specimen procedure.		

The student has satisfactorily completed the procedure "SPECIMEN COLLECTION" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 50

COURSE TITLE: NURSE ASSISTANT

UNIT VII: ELIMINATION

SCOPE OF UNIT:

This unit covers all aspects of the elimination of urine and stool, which includes care of the catheter, bowel and bladder retraining, giving and removing the urinal and bedpan, giving an enema, collecting specimens and testing urine for sugar and acetone.

INFORMATION TOPIC: or DEMONSTRATION VII-50

URINE TESTING FOR SUGAR AND ACETONE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to test urine for sugar using a Clinitest or Tes-Tape according to the steps of procedure.
2. Demonstrate how to test urine for acetone/ketones using the Acetone or Ketostix according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Clinitest kit (includes dropper, test tube, and tablets)
2. Running water
3. Tes-Tape
4. Acetone test tablet, paper towel, eyedropper
5. Ketostix/Labstix, any type of dipstick
6. Fresh urine specimen

TEACHER RESOURCES:

INTRODUCTION:

Urine testing is done on a regular basis for diabetic clients to monitor their disease. Sugar and acetone spill into the urine if there is a high level within the blood. Again accuracy is extremely important. The specimen that is collected should be as fresh as possible, and should not have been sitting in the bladder overnight or for several hours. Inform the charge nurse if you were unable to collect a fresh specimen. Dosages of insulin are sometimes calculated depending upon what the test results are.

The following procedure covers a variety of equipment. If your facility does not have these types of supplies, follow the directions that come with the test kits available.

LESSON PLAN: 50

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

STEPS OF PROCEDURE:

Clinitest

Steps beginning procedure

1. Identify and greet client. Identify self.
2. Explain what you are going to do.
3. Obtain fresh urine specimen.
4. Assemble necessary equipment.
5. Wash your hands.
6. Put on disposable gloves.

Clinitest procedure

7. Hold test tube between thumb and forefinger, about 1/4 inch from top of tube.
8. Turn on water faucet; draw up water into dropper; hold dropper upright and place ten drops of water into the center of the test tube.
9. Use the dropper to draw up urine from the specimen. With the dropper in an upright position, add the required number of drops of urine to the test tube (two drops/five drops).

   NOTE: Check tablet box for correct amount--either two drops or five drops--of urine to be added.
10. Pour one Clinitest tablet from the bottle into the bottle cap and drop it into the test tube.

    NOTE: Never touch the tablet with your fingers; check for normal color of tablet--bluish white and slightly spotted.
11. Hold test tube near top; do not shake the test tube during the reaction.
12. Count for 15 seconds after the bubbling inside the test tube has stopped; shake the tube gently side to side.

	YES	NO
B. Tes-Tape procedure		
7. Tear off a piece of tape about one and one-half inches long.		
8. Dip the end of the tape into the urine sample up to about one-half inch. Pull it back out.		
9. Wait for one minute, holding the tape.		
10. After a minute, compare the color change in the tape with the color chart on the tape container.		
11. Record the results.		
12. Discard tape and urine.		
C. Steps ending procedure		
13-15. Complete steps 17-19 of Clinitest procedure.		
Acetest tablet procedure		
A. Steps beginning procedure		
1-6. Complete steps 1-6 of Clinitest procedure.		
7. Place one acetest tablet on a clean paper towel.		
8. Draw urine into the dropper.		
9. Drop one drop of urine on the tablet.		
10. Wait 30 seconds.		
11. Compare the color of the tablet with the color chart on the bottle.		

LESSON PLAN: 51

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: VIII-51 OR DEMONSTRATION:

PRINCIPLES OF RESTORATIVE NURSING

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define restorative nursing.
2. List three reasons for providing restorative nursing.
3. Identify four complications of immobility that must be prevented.
4. Identify key points of positioning clients confined to bed.
5. Recognize the goals of restorative nursing.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Concept Media Filmstrip: "Fundamental Concepts of Nursing"; Program 6 - "Limited Activity," Parts I and II
2. Filmstrip or Film

TEACHER RESOURCES:

INTRODUCTION:

The human body is made for movement and action. When it becomes immobile or inactive due to a variety of conditions or illnesses, problems will develop. Basic nursing care can prevent many of these problems. All clients should be assisted to maintain or improve their present level of function rather than losing it. The physical therapist or physical therapy aide will be working with the client for a short period of time during the day; then it is up to other members of the nursing staff to continue with the established program. It is a 24-hour-a-day concern. Involve the family, if possible. This lesson will provide you with information concerning why restorative nursing is so critical to the clients and the vitally-important role of the nurse assistant.

LESSON PLAN: 51

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

OUTLINE: (Key Points)

I. Terms and Definitions:

   A. Orthostatic hypotension - inability of cardiovascular system to respond quickly enough to body position change, causing a drop in blood pressure; often accompanied by dizziness, fainting, or fall

   B. Restorative nursing - the process by which a disabled or ill person is helped to reach the highest possible level of wellness, considering his/her limitations (CD-1, 2)

II. Reasons for Providing Restorative Nursing:

   A. To maintain present function, follow basic nursing care measures.

      1. Provide exercise.

         a. Range of motion

            1) Active - client exercises alone; may use a device such as a pulley or exercise bicycle

            2) Active-assistive - N.A. helps client with exercises

            3) Passive - done for client who is unable to move independently; involves moving the client's body parts through a series of exercises

         b. Isometrics - independently by client

         c. Sitting with balance

         d. Standing causes body weight to rest on bones and muscles.

         e. Ambulation with assistance

         f. Self-care in activities of daily living

    2. Adequate fluid intake and proper diet

       Proper body positioning when in bed or sitting in a chair

    4. Change of position every two (2) hours

    5. Deep breathing and coughing

        a. Necessary to fill lungs completely with air and prevent any collapse of lungs

        b. Have client take in three (3) deep breaths through the nose, then blow out through the mouth, and then cough after the third breath.

B. To restore lost function

    1. Follow instructions given by therapist (physical therapist, occupational therapist, speech therapist)

    2. Restore independence in ADL (activities of daily living)

        a. Eating - teach client to feed self again; at first, have client hold finger foods, then progress as client is able; use adaptive utensils

        b. Sleeping - keep awake in daytime, except for short nap in early afternoon; bedtime should not be before 8:30 p.m.

        c. Dressing - encourage self-dressing; teach different methods to handicapped

        d. Toileting - encourage self-help; position client properly for voiding/defecating (standing/sitting); establish routine

        e. Exercise and ambulation

C. To prevent complications of immobility (CD-3)

    1. Pressure sores (decubitus ulcers, bedsores) - destruction of skin, muscle, and surrounding tissues because of pressure that cuts off blood supply to tissues

        a. Relieve pressure by regular turning and repositioning.

        b. Gentle massage of body prominences

   c. Keep client clean and dry.

   d. Encourage nutritious, high protein diet.

2. Contractures - deformity of joint due to shortening of muscles and tendons, which causes decrease in joint motion

   a. Change position every two (2) hours.

   b. Provide support to joints with a pad/pillow.

   c. Exercise joints.

   d. Apply aids to prevent contractures.

3. Constipation/impaction - can be caused by slowing down of peristalsis

   a. Adequate fluids and diet

   b. Exercise

   c. Bowel and bladder training

4. Lung congestion/pneumonia - lungs do not inflate fully and secretions cannot be moved up and out of lungs; accumulation of secretions can lead to an infection

   a. Encourage deep breathing and coughing.

   b. Exercise

   c. Adequate fluid intake

5. Circulatory problems - orthostatic hypotension can lead to blood clots (due to poor circulation)

   a. Turning

   b. Exercise

   c. Gradually change position of client.

   d. Move client out of bed into chair as soon as possible, as often and for as long as client can tolerate.

III. Positioning of Client Confined to Bed

   A. Has a tendency to lie in a curled up position (fetal position)

B. May bend his/her back and flex his/her knees and hips (may be lying in this position to relieve pain or to keep warm); client should not stay in this position for very long, he/she will have problems straightening out when able to get out of bed

C. The bed should support the natural curve of the spine.

D. Legs and arms should be supported to prevent strain on the joint and muscle contractures.

E. Linen should never be tucked too tightly over the feet (could cause footdrop); bed cradles may be placed over the legs and feet.

F. Supportive devices may be positioned at the shoulders, arms, hands, hips, knees and ankles and feet to prevent strain and maintain body alignment.

G. Position should be changed every two hours.

IV. Goals of Restorative Nursing

A. Emphasize abilities, not disabilities.

B. Keep the client functioning at the highest level possible.

C. Encourage independence when giving care; it may be faster and easier for you to do any of the activities of daily living for the client, but remember if you do it the client will not have the opportunity to try to do it.

D. Promote activity so strength of the body muscles is not lost.

E. Show interest in the client.

F. Praise the client when he/she has accomplished a task. Give your support.

V. Summary and Conclusion

A. Terms and definitions

B. Reasons for providing restorative nursing

C. Positioning of client confined to bed

D. Goals of restorative nursing

13. Compare color in the tube with the Clinitest color chart.

14. Record the results.

15. Wash test tube with cold water. Replace it upside down so that any remaining water will drain out.

16. Rinse dropper with cold water. Put it in rack in upright position.

Steps ending procedure

17. Remove, clean, and store equipment.

18. Wash your hands.

19. Record results on chart and notify charge nurse of results.

Tes-Tape

Steps beginning procedure

1-6. See steps 1-6 of Clinitest procedure.

Tes-Tape procedure

7. Tear off a piece of tape about one and one half inches long.

   NOTE: Do not touch the part of the tape that is to be dipped in the urine with your fingers.

8. Dip the end of the tape into the urine sample up to about one-half inch. Pull it back out.

9. Wait for one minute, holding the tape.

10. After a minute, compare the color change in the tape with the color chart on the tape container.

11. Record the results.

12. Discard tape and urine.

Steps ending procedure

13-15. See steps 17-19 of Clinitest procedure.

Acetest

Steps beginning procedure

1-6. See steps 1-6 of Clinitest procedure.

Acetest tablet procedure

7. Place one acetest tablet on a clean paper towel.

   NOTE: Without touching tablet, drop it into container lid and then onto the paper towel.

8. Draw urine into the dropper.

9. Drop one drop of urine on the tablet.

10. Wait 30 seconds.

11. Compare the color of the tablet with the color chart on the bottle.

12. Record the results.

13. Discard tablet, paper towel and urine.

Steps ending procedure

14-16. See steps 17-19 of Clinitest procedure.

Ketostix

Steps beginning procedure

1-6. See steps 1-6 of Clinitest procedure.

Ketostix procedure

7. Take a strip out of the bottle.

   NOTE: Do not touch the end to be dipped into the urine with your fingers.

8. Dip the specially-treated end into the urine with your fingers.

9. Wait 15 seconds.

10. Compare the color change on the strip with the color chart on the bottle.

11. Record the results.

12. Discard strip and urine.

Steps ending procedure

13-15. See steps 17-19 of Clinitest procedure.

SUMMARY AND CONCLUSION:

1. Classroom discussion items
2. Review steps of procedure

LESSON PLAN: 50

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

CLASSROOM DISCUSSION:

1. How do you obtain the freshest sample of urine?
2. Why is it important to be accurate?
3. What position should the dropper be in when putting drops into the test tube?
4. What is the proper way to put tablets into the test tube?
5. How do you replace the test tube in the kit after you have completed the Clinitest?
6. How much test paper is needed to do the Tes-Tape procedure?
7. How many drops of urine are placed on the acetest tablet?
8. What should you do with the results of any of these tests?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates testing the urine with whatever equipment is available in the particular facility.
2. Students practice testing the urine for sugar and acetone using available equipment.

LESSON PLAN: 50

COURSE TITLE: NURSE ASSISTANT

UNIT VII : ELIMINATION

EVALUATION ITEMS: NAME OF STUDENT: ____________________

URINE TESTING FOR SUGAR AND ACETONE

EQUIPMENT

1. Clinitest kit
2. Running water
3. Tes-Tape
4. Acetone test tablet, paper towel, dropper
5. Ketostix/Labstix, any type of dip stick
6. Fresh urine specimen

DID THE STUDENT	YES	NO
Clinitest		
A. Steps beginning procedure		
1. Identify and greet client Identify self.		
2. Explain what you are going to do.		
3. Obtain fresh specimen of urine.		
4. Assemble necessary equipment.		
5. Wash hands.		
6. Put on disposable gloves.		
B. Clintest procedure		
7. Hold test tube between thumb and forefinger, about 1/4 inch from top of tube.		
8. Turn on water faucet; draw up water into dropper; hold dropper upright and place ten drops of water into the center of the test tube.		

	YES	NO
9. Use the dropper to draw up urine from the specimen. With the dropper in an upright position, add the required number of drops of urine into test tube.		
10. Pour one Clinitest tablet from the bottle into the bottle cap and drop it into the test tube.		
11. Hold test tube near top; do not shake the test tube during the reaction.		
12. Count for 15 seconds after the bubbling inside the test tube has stopped. Shake the tube gently from side to side.		
13. Compare color in the tube with the Clinitest color chart.		
14. Record the results.		
15. Wash test tube with cold water. Replace it upside down so that any remaining water will drain out.		
16. Rinse dropper with cold water. Put it in rack in upright position.		
C. Steps ending procedure 17. Remove, clean, and store equipment.		
18. Wash hands.		
19. Record results on chart, and notify charge nurse of results.		
Tes-Tape A. Steps beginning procedure 1-6. Complete steps 1-6 of Clinitest procedure.		

	YES	NO
12. Record the results.		
13. Discard tablet, paper towel and urine.		
C. Steps ending procedure 13-15. Complete steps 17-19 of Clinitest procedure.		
Ketostix A. Steps beginning procedure 1-6. Complete steps 1-6 of Clinitest procedure.		
B. Ketostix procedure 7. Take a strip out of the bottle.		
8. Dip the specially-treated end into the urine sample; pull back out; let excess urine drip off.		
9. Wait for 15 seconds.		
10. Compare the color change on the strip with the color chart on the bottle.		
11. Record results.		
12. Discard strip and urine.		
C. Steps ending procedure 13-15. Complete steps 17-19 of Clinitest procedure.		

The student has satisfactorily completed the procedure "URINE TESTING FOR SUGAR AND ACETONE" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

Date

You may apply this information to all of your clients. It is basic nursing care. Many clients already have complications, and you can still apply these principles of restoration. If you observe a problem developing, be sure to report it to the charge nurse so the entire health care team can provide the care needed and hopefully improve the quality of life for the client.

LESSON PLAN: 51

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

CLASSROOM DISCUSSION:

1. Can you think of some illnesses or conditions that may cause a client to be immobile?
2. Have any of you ever been immobilized for a long period of time? How did you feel when you were able to get up again?
3. If you were confined to bed for a week, can you think of some complications that may develop if you were not able to care for yourself?
4 How important is it for you to allow the client to do things for him/herself, rather than doing them for him/her?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip or film

LESSON PLAN: 51

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS:

1. Define orthostatic hypotension.

2. What is restorative nursing?

3. List three reasons for providing restorative nursing.

4. Which of the following are complications that can develop due to immobility? (Circle the letter of the correct answer.)

   a. Contractures, blood clots, pressure sores, or constipation

   b. Contractures, diarrhea, pressure sores, or constipation

   c. Contractures, blood clots, diaphoresis, or constipation

   d. Halitosis, blood clots, pressure sores, or constipation

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 5. It is much better to brush the client's teeth than to allow the client to take ten minutes to accomplish it.

____ 6. Praise the client when he/she has accomplished a task.

____ 7. A goal of restorative nursing is to keep the client functioning at the highest level possible.

____ 8. Emphasize the client's disabilities.

____ 9. Linen should never be tucked too tightly over the feet.

____10. Position of the bedridden client should be changed every three hours.

LESSON PLAN: 51

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

ANSWERS TO EVALUATION ITEMS:

1. Orthostatic hypotension - inability of cardiovascular system to respond quickly enough to body position change, causing a drop in blood pressure, often accompanied by dizziness, fainting or fall

2. Restorative nursing is the process by which a disabled or ill person is helped to reach the highest possible level of wellness, considering his/her limitations.

3. a. To maintain present function
   b. To restore lost function
   c. To prevent complications of immobility

4. a
5. F
6. T
7. T
8. F
9. T
10. F

LESSON PLAN: 52

COURSE TITLE: NURSE ASSISTANT

UNIT VIII **:** RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: VIII-52 OR DEMONSTRATION:

BODY MECHANICS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define body mechanics.
2. Identify two reasons body mechanics are important.
3. Recognize key points of body mechanics.
4. Identify additional points to consider when moving a client or object.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. **HO 1: Key Points in Body Mechanics**
2. **Trainex filmstrip #316: "How to Work All Day Without Getting Hurt"**

TEACHER RESOURCES:

INTRODUCTION:

As a nurse assistant, one of your major duties will be to move clients. You must know how to do this without straining your back and causing an injury to yourself or the client. There are ways to use your body to reduce strain and fatigue and that is what the next lesson will cover.

LESSON PLAN: 52

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

OUTLINE: (Key Points)

I. Body Mechanics - using correct movement of the body in performing certain functions in a manner that does not add undue strain

II. Importance of Body Mechanics

   A. Protects you from injury by aligning body segments to each other; by standing straight, the main parts of your body (head, chest and pelvis) are properly aligned one over the other to maintain good balance (CD-1)

   B. Reduces fatigue to prevent strain on the spine

   C. Makes the spine work with you and for you to maximize body strength

   D. Makes lifting, transferring, and moving objects easier to minimize fatigue

   E. Provides balance and stability

III. Key Points in Body Mechanics (HO 1)

   A. When moving a client, be sure he/she knows when he/she is going to be lifted, how you plan to do it, and where you are going to lift him/her to. Use verbal cues.

   B. Determine what has to be done and if you will need help. Never attempt to lift alone if you feel that you will not be able to do so safely.

   C. Place feet apart (about 18 inches) with one slightly ahead of the other. Feet should be shoulder-width apart to give you a broad base of support.

   D. Get close to whatever is being lifted, instead of reaching for it. Move in and hold the object close to your body.

   E. Keep your back straight; bend at the hips and knees. (CD-2)

F. Straighten your legs and use your upper arm and leg muscles to lift.

G. Lift smoothly to avoid strain produced by jerky movements. Use verbal cues to signal your coworker when it is time to lift; .e. count, "one, two, three, LIFT!"

H. To turn, pivot with your feet--never twist your body.

I. Push, pull, slide and roll whenever possible, rather than lift.

J. Remind coworkers to use good body mechanics.

IV. Additional Points

A. Always look for any obstacles or hazards before moving a client.

B. When an action requires physical effort, try to use as many muscles as possible. For example, use both hands rather than one hand to pick up a heavy piece of equipment.

C. When you lift an object or need to pick something up off the floor, squat rather than bend over. This will reduce strain on the spine.

V. Summary and Conclusion

A. Body Mechanics

B. Importance of body mechanics

C. Key points in body mechanics

D. Additional Points

The importance of understanding and using proper body mechanics cannot be overemphasized. Serious injury to either or both the nursing assistant and client can occur as a result of improper lifting/transfer techniques.

LESSON PLAN: 52
COURSE TITLE: NURSE ASSISTANT
UNIT VIII : RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. What is good posture?

2. What muscle groups should you use when lifting?

e. How can you signal your coworkers that you are ready to move a client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip or film

2. Have students lift box off floor using proper body mechanics.

LESSON PLAN: 52

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

EVALUATION ITEMS:

1. Define body mechanics.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 2. Body mechanics protect you from injury and reduce fatigue.

_____ 3. Body mechanics provide imbalance and instability.

_____ 4. Your feet should be as far apart as possible to give you a broad base of support.

_____ 5. When lifting an object/client keep your back flexed and bend using your back muscles.

_____ 6. To turn, pivot with your feet, never twist your body.

_____ 7. Push, pull, or slide whenever possible, rather than lift.

_____ 8. If a heavy client must be moved, and no coworkers are available to help, go ahead and try to lift the client by yourself.

_____ 9. Always count or signal coworkers when it is time to lift.

_____10. Inform the client when, how and where you are going to lift him/her.

_____11. Always stand 12 inches away from whatever is being lifted.

_____12. When picking something up off the floor bend at the waist and reach over to pick it up.

_____13. Always look for any obstacles or hazard before moving a client.

LESSON PLAN: 52

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

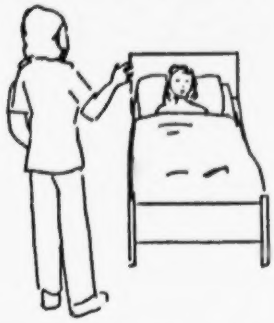
ANSWERS TO EVALUATION ITEMS:

1. Body mechanics - using correct movement of the body in performing certain functions in a manner that does not add under strain.

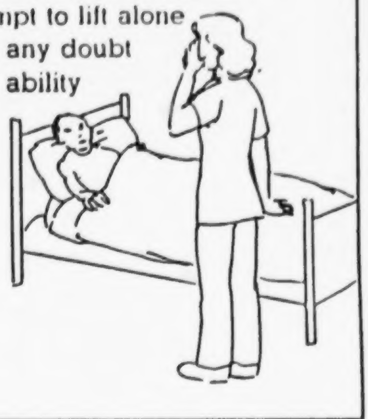
2. T
3. F
4. F
5. F
6. T
7. T
8. F
9. T
10. T
11. F
12. F
13. T

KEY POINTS IN BODY MECHANICS

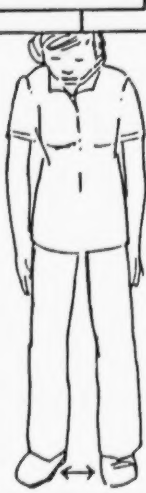
1. When you are lifting a client be sure that the client knows you are lifting, how you plan to lift, and where you are going to lift him/her to.



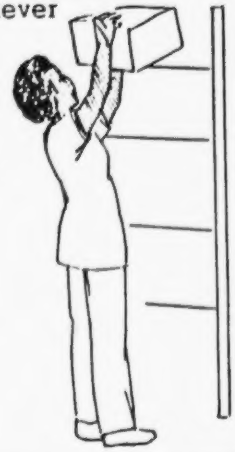
2. Size up the load to be lifted. Do not attempt to lift alone if you have any doubt about your ability to do so.



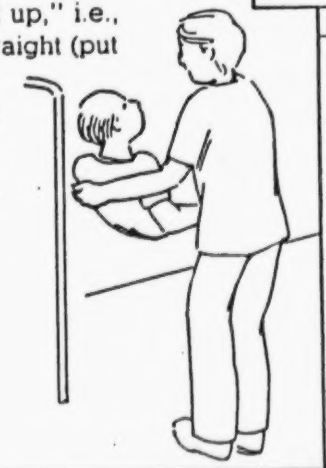
3. Check your footing. Your feet should be shoulder width apart to give you a broad base of support (good balance).



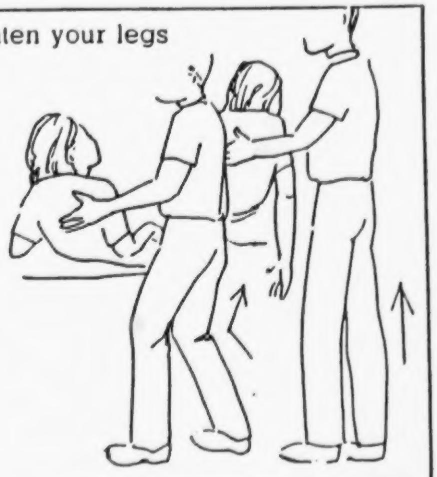
4. Get close to whatever is being lifted instead of reaching for it. Move in and hold it close.



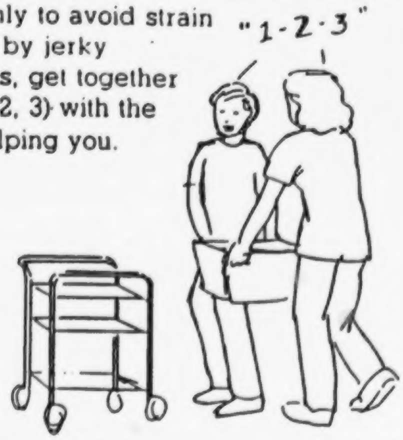
5. Get yourself "lined up," i.e., keep your back straight (put on "high midriff") bend at the knees and hips.



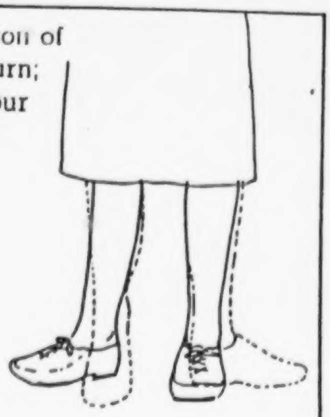
6. Straighten your legs to lift.



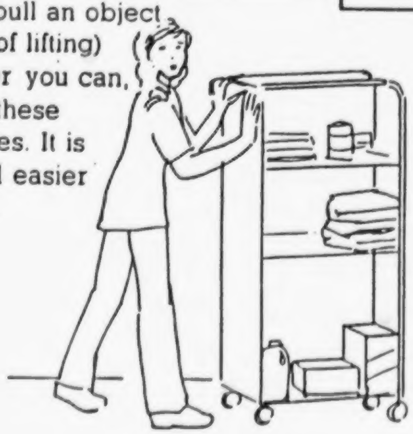
7. Lift smoothly to avoid strain produced by jerky movements, get together (Ready 1, 2, 3) with the person helping you.



8. Shift the position of your feet to turn; never twist your body.



9. Push or pull an object (instead of lifting) whenever you can, and use these same rules. It is safer and easier that way.



10. Remind co-workers to use good body mechanics.

LESSON PLAN: 53

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: OR DEMONSTRATION: VIII-53

LIFTING AND MOVING THE CLIENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to move a client who can assist to the head of the bed according to the steps of procedure.
2. Demonstrate how to move a helpless client to the head of the bed according to the steps of procedure.
3. Demonstrate how to move a client to one side of the bed according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Moving the Client in Bed.
2. Trainex Filmstrip #375: "Lifting and Moving Patients"
3. Bed with side rails

LESSON PLAN: 53

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

STEPS OF PROCEDURE:

Moving Client Who Can Assist to Head of Bed

Steps beginning procedure

1. Wash your hands
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Provide privacy.
5. When possible, raise bed to a comfortable working height; lock wheels on bed; lower backrest, lower side rail on side at which you are working.
6. If the client has any tubing coming from body and it is pinned to the bedding, unfasten it so that it will move freely with the client.

Steps of procedure

7. Remove pillow and move it to headboard to client does not hit his/her head when moving up.
8. Help client bend his/her knees and press feet firmly against the mattress.
9. If client is able, have him/her grasp head of bed, otherwise cross his/her arms over chest.
10. Slide one arm under client's shoulders and the other under the thighs.
11. Position your body facing toward the head of the bed and stand with your feet 18 inches apart, one foot slightly ahead of the other.
12. On the count of three, have the client push with his/her feet and you shift your weight from your back leg to your front leg as you slide the client up in the bed.
13. Replace pillows.

14. Adjust backrest for comfort.

Steps ending procedure

15. Lower bed to a position of safety; raise side rails where ordered.

16. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

17. Wash your hands.

Moving Helpless Client to Head of Bed

1. Ask another nurse assistant to work with you.

2-7 See steps 1-6 of moving client who can assist procedure.

Steps of Procedure

8. Remove pillow and move it to headboard so client does not his his/her head when moving up.

9. Each nursing assistant should stand on one side of the bed.

10. If pull sheet is not in place, position a draw sheet/folded regular sheet under shoulders and hip area. Roll edges of sheet toward client's body on both sides and grasp rolled sheet with your hands at the client's shoulders and at the mid-hip area.

    NOTE: If pull sheet is not available, each NA should grasp under the client's shoulder and buttocks.

11. Your feet should be pointed in the direction you are moving the client; bend knees, keep back straight.

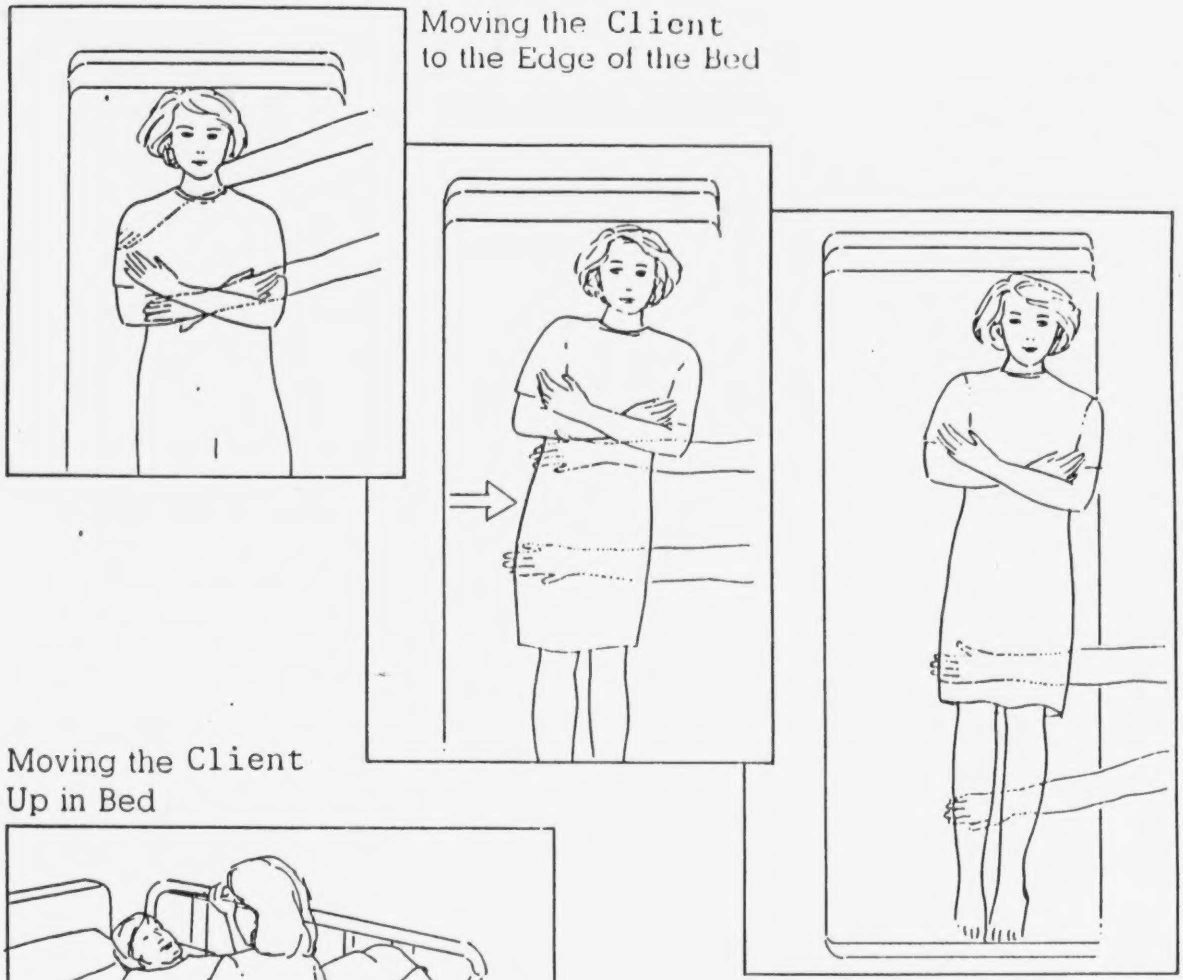
12. On the count of three, each nursing assistant lifts the client up off the surface of the bed and toward the head of the bed while shifting weight from back foot to front foot.

13. Replace pillow.

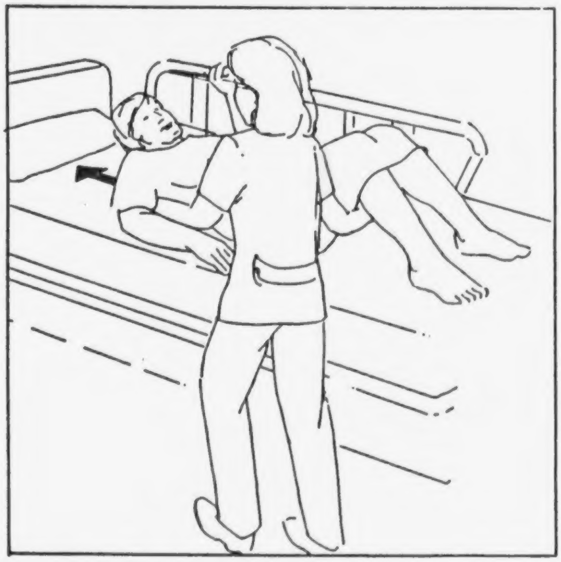
14. Adjust backrest for comfort.

MOVING THE CLIENT IN BED

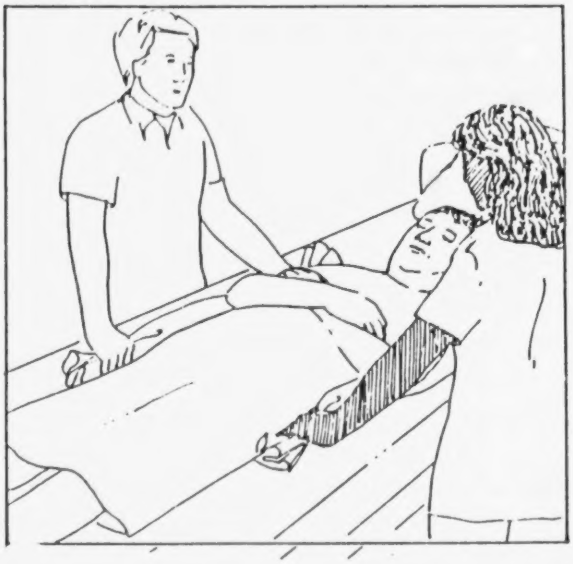
Moving the Client to the Edge of the Bed



Moving the Client Up in Bed



Using a Pull Sheet



TEACHER RESOURCES:

INTRODUCTION:

Clients will often need help when moving in the bed. You must assess your clients properly to determine if you can move him/her by yourself or if you will need help. If the procedure requires two persons due to the client being "dead weight," very heavy, or one with very fragile skin, use a pull/lift sheet. This will prevent friction and irritation to the skin. Keep in mind the principles of body mechanics anytime you are moving the client.

Steps ending procedure

15-17. See steps 15-17 of moving client who can assist procedure.

Moving Client to One Side of the Bed:

Steps beginning procedure

1-6 See steps 1-6 of moving client who can assist procedure.

Steps of procedure

7. Remove pillow, loosen top sheets, but don't expose the client.
8. Stand on the side of the bed toward which you intend to move client.
9. Slide both arms under the client's back to his/her far shoulder, then slide the client's shoulders toward you on your arms.
10. Slide both your arms as far as you can under the client's buttocks and slide his/her buttocks toward you. Use a lift sheet whenever possible.
11. Keep your knees bent and your back straight as you slide the client.
12. Place both your arms under the client's feet and slide them toward you on your arms.
13. Repace pillows.
14. Adjust backrest for comfort.

Steps ending procedure

15-17 See steps 15-17 of moving client who can assist procedure.

SUMMARY AND CONCLUSION:

1. Ask Classroom Discussion Items.
2. Review steps of procedures.

LESSON PLAN: 53

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. How do you prepare the area and the client before lifting the client?
2. What body mechanics does the nursing assistant use?
3. If the client can assist, how do you instruct him/her to help?
4. Where does the second person stand when two persons are lifting a helpless client?
5. What is the purpose of the lift sheet?
6. What part of the body do you move first, when moving a client to the side of the bed?
7. What can be the result of failing to synchronize with verbal cues when two persons are working together in a lifting procedure?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show Filmstrip or Film
2. Instructor demonstrates how to move a client up in the bed and how to move a client from one side of the bed to the other.
3. Students practice moving another student up in bed and moving another student from one side of the bed to the other.

LESSON PLAN: 53

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS: NAME OF STUDENT ____________________

LIFTING AND MOVING THE CLIENT

EQUIPMENT

1. Bed with side rails

DID THE STUDENT	YES	NO
Moving Client Who Can Assist to Head of Bed		
A. Steps beginning procedure 1. Wash hands.		
2. Identify and greet client. Identify self.		
3. Explain procedure to client.		
4. Provide privacy.		
5. Raise bed to a comfortable working height; lock wheels on bed; lower backrest, lower side rail on appropriate side.		
6. If the client has any tubing coming from body and it is pinned to the bedding, unfasten it so that it will move freely with the client.		
B. Steps of procedure 7. Remove pillow and move it to headboard so client does not hit his/her head when moving up.		

	YES	NO
8. Help client bend his/her knees and press feet firmly against the mattress.		
9. If client is able, have him/her grasp head of bed, otherwise cross his/her arms over chest.		
10. Slide one arm under client's shoulders and the other under the thighs.		
11. Stand facing the head of the bed with feet 18 inches apart, one foot slightly ahead of the other.		
12. On the count of three, have the client push with feet as nurse assistant shifts weight from back leg to front leg and slides client up in the bed.		
13. Replace pillows.		
14. Adjust backrest for comfort.		
C. Steps ending procedure 15. Lower bed to a position of safety; raise side rails where ordered.		
16. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
17. Wash hands.		
Moving Helpless Client to Head of Bed A. Steps beginning procedure 1. Ask for assistance from another nurse assistant.		
2-7. Complete steps 1 through 6 of moving client who can assist procedure.		

	YES	NO
B. Steps of Procedure 8. Remove pillow and move it to headboard so client does not hit his/her head when moving up.		
9. Each nursing assistant should stand on one side of the bed.		
10. If pull sheet is not in place, position a draw sheet/ folded regular sheet under shoulders and hip area. Roll edges of sheet toward client's body on both sides and grasp rolled sheet with hands at the client's shoulders and at the mid-hip area.		
11. Point feet in the direction in which client is to be moved; bend knees, keep back straight.		
12. On the count of three, each nursing assistant lifts the client up off the surface of the bed and toward the head of the bed using correct body mechanics.		
13. Replace pillow.		
14. Adjust backrest for comfort.		
C. Steps ending procedure 15-17. Complete steps 15 through 17 of moving client who can assist procedure.		
Moving Client to One Side of the Bed A. Steps beginning procedure 1-6. Complete steps 1 through 6 of moving client who can assist procedure.		
B. Steps of procedure 7. Remove pillow, loosen top sheets without exposing client.		
8. Stand on the side of the bed toward which the client is to be moved.		

	YES	NO
9. Slide both arms under the client's back to his/her far shoulder, then slide the client's shoulder in the direction of the move.		
10. Slide both arms as far as possible under the client's buttocks in the direction of the move. Use a lift sheet whenever possible.		
11. Keep knees bent and back straight while sliding client.		
12. Place both arms under the client's feet and slide them in the direction of the move.		
13. Replace pillows.		
14. Adjust backrest for comfort.		
C. Steps ending procedure.		
15-17. Complete steps 15 through 17 of moving client who can assist procedure.		

The student has satisfactorily completed the procedure "LIFTING AND MOVING THE CLIENT" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 54

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: OR DEMONSTRATION: VIII-54

TURNING AND POSITIONING THE CLIENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to turn the client in bed toward the nurse assistant and position on side according to the steps of procedure.
2. Demonstrate how to turn the client in bed away from the nurse assistant and position on side according to the steps of procedure.
3. Demonstrate how to properly position the client in the prone position.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Turning the Client
2. HO 2: Positioning the Client
3. Trainex filmstrip #398: "Positioning to Prevent Complications"
4. Projector
5. Bed with side rails
6. Two pillows - additional blankets/towels as needed
7. Handrail/wash cloth

TEACHER RESOURCES:

INTRODUCTION:

Proper positioning of the client in the bed is necessary to maintain normal body function, to prevent contractures, to assure comfort and to prevent pressure on one area of the body. Body alignment is the proper relationship of body parts to each other when positioning him/her to see if the body is straight and looks comfortable; check to make sure no bony areas are pressing/rubbing on the mattress. The following procedures will assist you in understanding the steps to take for turning a client on his/her side and to the prone position (in which the client is lying on his/her abdomen). This latter position will extend the body more than any other position. This can help prevent flexion contractures of the hip.

LESSON PLAN: 54
COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

STEPS OF PROCEDURE:

Turning the Client Toward You to Side-Lying Position

Steps beginning procedure

1. Wash your hands
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Provide privacy.
5. When possible, raise bed to a comfortable working height; lock wheels on bed; lower backrest, lower side rail on side at which you are working.
6. If the client has any tubing coming from body and it is pinned to the bedding, unfasten it so that it will move freely with the client.

Procedure for turning the client toward you

7. Loosen the top sheets; do not expose the client. Remove pillow.
8. Check to see that the client has ample space to turn without getting too close to the edge of the bed; if not, have client move over more in bed, or you move the client to the side of the bed that he/she is not turning to.
9. Cross the leg furthest from you over the leg closest to you.
10. Cross the client's arms over his/her chest.
11. Reach across the client and put one hand behind his/her far shoulder.
12. Place your other hand behind his/her far hip, gently roll him/her toward you.
13. Fold a pillow lengthwise and place it against the client's back for support.

14. Support the client's head with the palm of one hand and with the other hand, slide a pillow under his/her head and neck.

15. Position client's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.

16. Support upper arm on pillow.

17. Place handrail or rolled washcloth in hand with thumb in opposition to fingers.

Steps ending procedure

18. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.

19. Lower bed to a position of safety; raise side rails where ordered.

20. Wash your hands.

Turning the Client Away From You to Side-Lying Position

Steps beginning procedure

1-6. See steps 1 through 6 of turning the client toward you procedure.

Procedure for turning the client away from you

7. Loosen the top sheets; do not expose the client. Remove the pillow.

8. Check to see that the client has ample space to turn without getting too close to the edge of the bed; if not, have client move over more in bed, or you move the client to the side of the bed that he/she is not turning to.

9. Cross the client's arms over his/her chest.

10. When turning a client away from you, cross the leg closest to you over the leg farthest from you.

11. Place one hand on the client's shoulder near you.

12. Put your other hand under client's buttocks, turn him/her gently on his/her side, facing away from you.

	YES	NO
C. Steps ending procedure 18-20. Complete steps 18 through 20 of turning the client toward NA procedure.		
Prone Position A. Steps beginning procedure 1-6. Complete steps 1 through 6 of turning the client toward NA procedure.		
B. Positioning the client in the prone position 7. Loosen top sheets, do not expose client. Remove pillows.		
8. Move client to side of bed you are on.		
9. Turn to side.		
10. Cross upper leg over lower leg.		
11. Roll client on to abdomen.		
12. Place small firm pillow/folded blanket under the head.		
13. Place small firm pillow under one shoulder.		
14. Place small firm pillow under abdomen to prevent pressure on breasts.		
15. Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.		
C. Steps ending procedure 16. Complete steps 18 through 20 of turning the client toward NA procedure.		

The student has satisfactorily completed the procedure "TURNING AND POSITIONING THE CLIENT IN BED" according to the steps outlined.

____
Instructor's signature
(Verifying Satisfactory Completion)

____
Date

13. Fold a pillow lengthwise and place it against the client's back for support.

14. Support the client's head with the palm of one hand and with the other hand, slide a pillow under his/her head and neck.

15. Keep knees slightly flexed, upper leg more than lower leg; support upper leg on pillow.

16. Support upper arm on pillow.

17. Place handrail or rolled washcloth in hand with thumb in opposition to fingers.

Steps ending procedure

18-20. See steps 18-20 of turning the client toward you procedure.

Prone Position

Steps beginning procedure

1-6. See steps 1 through 6 of turning the client toward you procedure.

Procedure for positioning the client in the prone position

7. Loosen top sheets, do not expose client. Remove pillows.

8. Move client to side of bed you are on.

9. Turn to side.

10. Cross upper leg over lower leg.

11. Roll client onto abdomen...

12. Place small firm pillow/folded blanket under the head.

    NOTE: Do not use a full pillow as it may cause neck strain and interfere with breathing.

13. Place small firm pillow under one shoulder.

14. Place small firm pillow under abdomen to prevent pressure on breasts.

15. Extend feet over end of mattress or slightly elevate feet off mattress by flexing knees and placing pillow under lower legs.

Steps ending procedure

16. See steps 18 through 20 of turning the client toward you procedure.

SUMMARY AND CONCLUSION:

1. Ask classroom discussion items.

2. Review steps of procedures.

LESSON PLAN: 54

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. What can you use if you have only two pillows?
2. When you turn a client to his/her side, what parts of the body will need support?
3. When positioning a client on his/her abdomen (prone) why wouldn't you use a full pillow under his/her head?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates turning and positioning client on side.
2. Instructor demonstrates turning and positioning client in the prone position.
3. Students practice turning and positioning client on side and prone position.
4. Show Filmstrip or Film.

LESSON PLAN: 54

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS:

NAME OF STUDENT__________________

TURNING AND POSITIONING THE CLIENT IN BED

EQUIPMENT

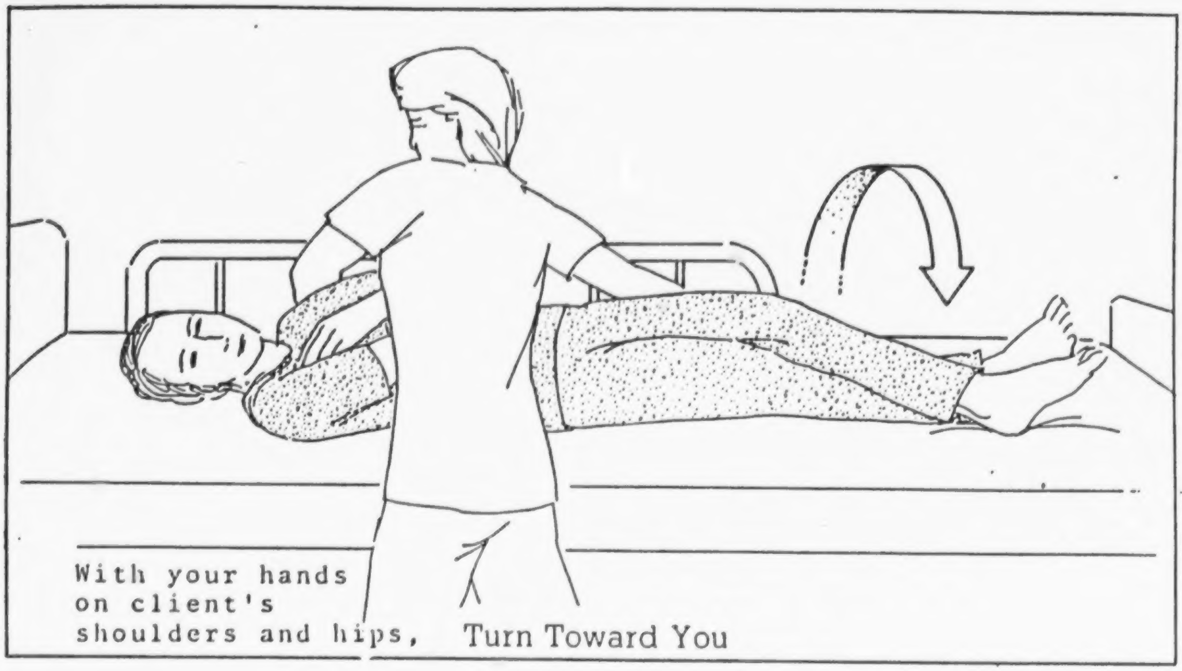
1. Bed with side rails
2. Two pillows - additional blankets/towels as needed
3. Handrail/wash cloth

DID THE STUDENT	YES	NO
Turning the Client Toward the Nurse Assistant to Side-Lying Position		
A. Steps beginning procedure		
1. Wash hands.		
2. Identify and greet client. Identify self.		
3. Explain procedure to client.		
4. Provide privacy.		
5. When possible, raise bed to a comfortable working height; lock wheels on bed; lower backrest, lower side rail on appropriate side		
6. If the client has any tubing coming from body and it is pinned to the bedding, unfasten it so that it will move freely with the client.		
B. Turning the client toward the nurse assistant		
7. Loosen the top sheets without exposing the client. Remove pillow.		
8. Allow the client ample space to turn without getting too close to the edge of the bed.		

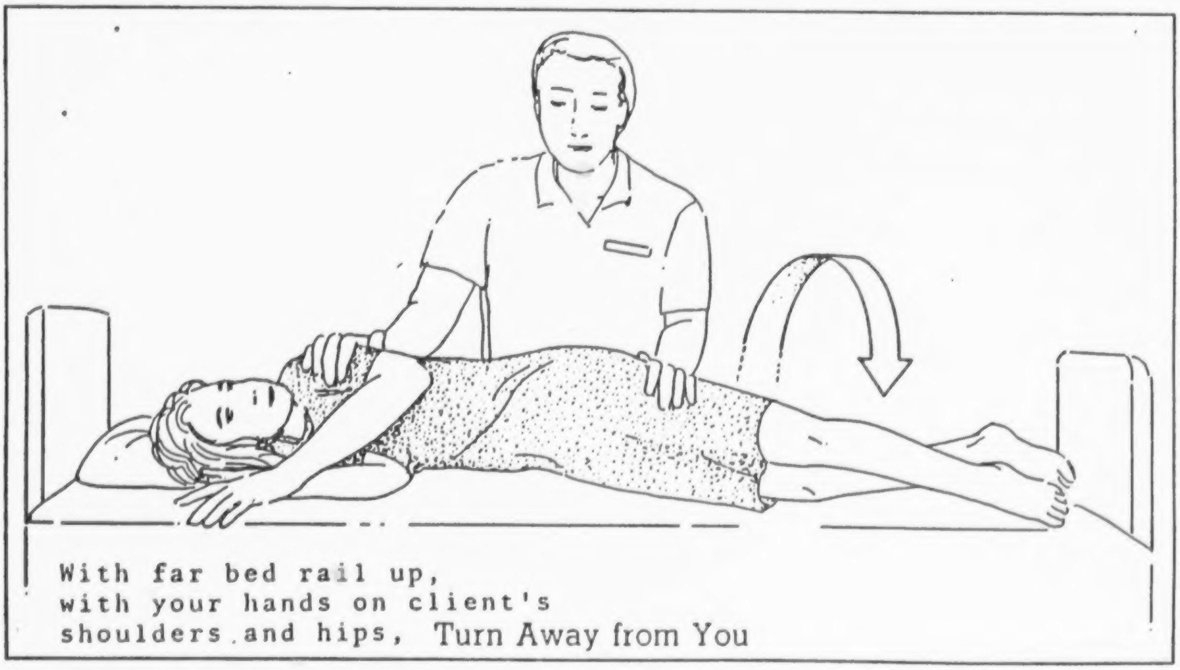
	YES	NO
9. Cross the far leg over the near leg.		
10. Cross the client's arms over his/her shoulder.		
11. Reach across the client and put one hand behind his/her far shoulder.		
12. Place other hand behind his/her far hip, gently roll him/her toward NA.		
13. Fold a pillow lengthwise and place it against the client's back for support.		
14. Support the client's head with the palm of one hand and with the other hand, slide a pillow under his/her head and neck.		
15. Position client's knees slightly flexed, upper leg more than the lower leg. Support upper leg on pillow.		
16. Support upper arm on pillow.		
17. Place handrail or rolled washcloth in hand with thumb in opposition to fingers.		
C. Steps ending procedure		
18. Make the client comfortable; place call signal within reach; fasten tubing if unpinned while moving client; adjust bedding.		
19. Lower bed to a position of safety; raise side rails where ordered.		
20. Wash hands.		

	YES	NO
Turning the Client Away From the Nurse Assistant to Side-Lying Position A. Steps beginning procedure 1-6. Complete steps 1 through 6 of turning the client toward NA procedure.		
B. Turning the client away from the nurse assistant. 7. Loosen the top sheets, without exposing the client. Remove the pillow.		
8. Allow the client ample space to turn without getting too close to the edge of the bed.		
9. Cross the client's arms over his/her chest.		
10. Cross the near leg over the far leg.		
11. Place one hand on the client's near shoulder.		
12. Put other hand under client's buttocks, turn him/her gently on his/her side, facing away.		
13. Fold a pillow lengthwise and place it against the client's back for support.		
14. Support the client's head with the palm of one hand and with the other hand, slide a pillow under his/her head and neck.		
15. Keep knees slightly flexed, upper leg more than lower leg; support upper leg on pillow.		
16. Support upper arm on pillow.		
17. Place handrail or rolled washcloth in hand with thumb in opposition to fingers.		

TURNING THE CLIENT

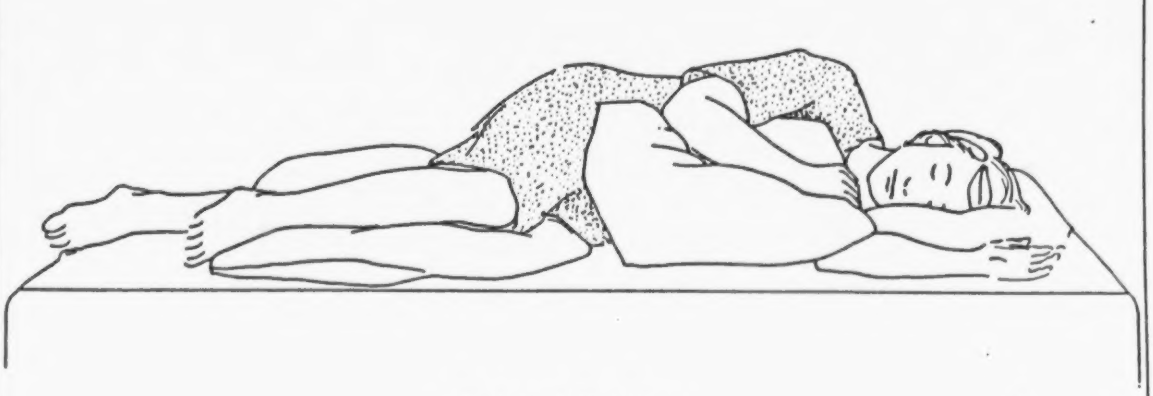


With your hands on client's shoulders and hips, Turn Toward You

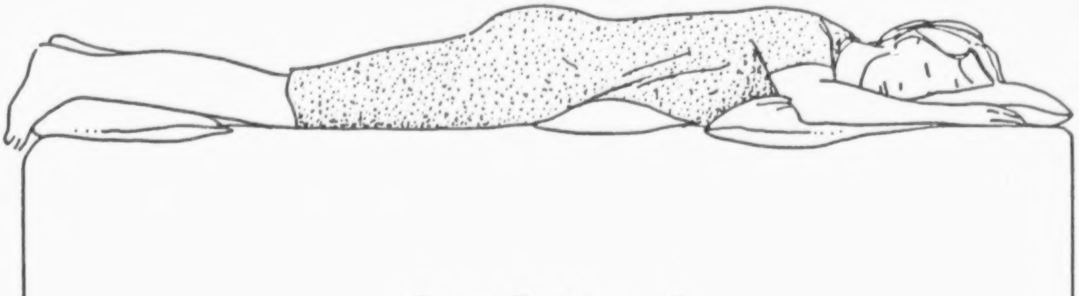


With far bed rail up, with your hands on client's shoulders and hips, Turn Away from You

POSITIONING THE CLIENT



Lateral Position



Prone Position

LESSON PLAN: 55

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: VIII-55 OR DEMONSTRATION:

PRINCIPLES OF TRANSFERRING CLIENTS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe two methods of active assistive transfer.
2. Identify five safety measures to observe when transferring clients.
3. Recognize three pieces of equipment used for transfer activities.
4. Identify what areas of the body must be checked for proper body alignment.
5. Describe the method of properly positioning a client who slides forward in the chair.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip #400: "Transfer Activities and Ambulation"
2. Filmstrip or film.
3. Projector
4. Chair, wheelchair, geri chair, or commode
5. Transfer belt
6. Hydraulic lift, if available.
7. Sliding board, if available.
8. Arm sling, if available.

TEACHER RESOURCES:

INTRODUCTION:

Clients in long-term care facilities or at home should be kept out of bed as much as their physical condition allows. Getting the client up and into a chair can prevent complications associated with being immobilized. If the client cannot walk, one way to make the client mobile and get him/her out of his/her room is to put the client in a wheelchair or geri chair. Many of the clients will be dependent upon your help to do this. It is necessary for you to understand some of the basic principles of transfer to accomplish this in a safe, efficient manner.

LESSON PLAN: 55

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

OUTLINE (Key Points)

I. Methods of Transfer (CD-1)

- A. Active assistive - client needs assistance in moving from place to place.
    - 1. Sitting transfers - client remains in sitting position when transferred.
    - 2. Standing transfers - client stands and pivots or takes steps to transfer.
        - a. Chair to bed; bed to chair
        - b. Chair to ambulation device
    - 3. Lying transfer
        - a. Bed to stretcher; stretcher to bed
        - b. Using a hydraulic lift
- B. Passive - client does not assist with transfer.

II. Safety measures

- A. When transferring clients who have a weak side, position the chair on his/her strong side.
- B. For a weak client, you need to have control of the shoulders and hips during transfer
- C. Do not attempt to transfer a client who cannot bear any of his/her own body weight by yourself. Determine beforehand how many people will be needed for the transfer; do not interrupt the procedure to go get more help.
- D. All wheelchairs or geri chairs should have locks which are locked during transfer; a slight movement of the wheelchair could cause a fall.
- E. Foot rests should be up and out of the way during transfer to prevent the client from tripping or stepping on the rests and falling.

F. Have all equipment handy and checked for safety before beginning procedures.

G. Give the client thorough explanations of how he/she is to assist. Give client encouragement and praise when he/she assists with the transfer.

H. Client's feet should be flat on the floor approximately 12 inches apart.

I. Practice good body mechanics.

III. Equipment for Transfer Activities

A. Sliding Board (CD-2)

1. A smooth, varnished or vinyl board with tapered edges about one foot wide and two feet long.

2. One end is tucked in place under the client and the other end is put on the chair or bed.

3. The client's body slides across the board. Dusting the board with talcum powder or cornstarch facilitates sliding.

4. The client may use a trapeze bar to place his/her hands to help him/her lift and move.

5. The board is helpful for a weak or paralyzed client who cannot stand up well enough to transfer to a chair.

6. The client must be moving to another surface of equal or lower height.

B. Transfer belt (CD-3)

1. A special belt which is placed around the client's waist and provides the nurse assistant with a handle to hold on to when moving the client.

2. It enhances both the safety and comfort of the transfer procedure; prevents injury to client which could be caused by pulling on arms.

3. Useful for ambulating clients--increases safety.

4. Apply the belt snugly but not so tight that it causes discomfort or impairs the client's ability to breathe.

C. Hydraulic lift

1. A device used to lift and move clients who are unable to do so on their own.

2. Two people are needed to use such a device safely.

3. A lift has the following parts:

   a. A sling in which the client sits

   b. An arm and frame that supports the sling

   c. A crank or lever that raises or lowers the arm of the frame.

D. Sling

1. A cloth device to cradle an arm or hand that may be injured or paralzed

2. Supporting the paralyzed extremity in a sling makes it easier for the client to balance in transfer and ambulation activities.

IV. Positioning the Client in a Chair

A The weight of the client should be supported by the upper legs and buttocks when sitting in a chair, wheelchair, or geri chair.

B. Check for proper body alignment

1. Head should be erect; control of head is necessary to maintain an upright position.

2. Arms supported with pillows.

3. Back should be straight against the back of the chair; place a small pillow at the lower back for comfort and support if client's sitting balance is good.

4. Hips and buttocks should be against the back of the chair.

5. The backs of the knees should be free of pressure from the edge of the chair; there should be room for two or three fingers between the back of the knees and the front of the chair.

6. Feet should be positioned flat on the footrests or the floor; should not be left to dangle.

TEACHER RESOURCES:

INTRODUCTION:

You should now have a clear understanding of the importance of getting a client up and out of the bed. You must learn to do this in a way that is safe and does not cause discomfort to the client. It will be an activity that you will assist the client with many times during your shift. The following procedure will provide you with the steps to take to transfer a client properly.

C. Position still needs to be changed every two hours and the client exercised; if possible, client should stand and walk at two-hour intervals. (CD-4)

D. Have the client shift his/her weight from one side of the buttocks to the other by leaning to the right side and then to the left side every 30 minutes.

E. For the client who slides forward in the chair: (CD-5)

1. Apply transfer belt.

2. Stand behind the chair and put your arms under the client's upper arms and grasp the client's wrists in front of the client's chest (his/her arms should be folded in front of his/her chest). On the count of three you pull the client up and back into the chair. If the client can help, have him/her push with his/her feet on footrests.

V. SUMMARY AND CONCLUSION:

A. Methods of transfer

B. Safety measures

C. Equipment for transfer activities

D. Positioning the client in chair

Almost all of the clients you will be taking care of will need to get out of bed at least once a day. You must plan ahead and think through the steps before you start. It can be very frightening for some clients who do not get out of bed very often. He/she may be scared that you will drop them or that he/she will fall. Take your time and encourage the client to help as much as possible.

LESSON PLAN: 55

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. What is the difference between an active assistive transfer and a passive transfer?

2. What type of client may use a sliding board? Would the client have to have good muscle strength of the upper extremities?

3. Where is the transfer belt placed on the client?

4. How often do you think a client in a chair should have his/her position changed?

5. A client calls you and states that he needs to go to the bathroom immediately, you have never lifted this man before by yourself, there have always been two people. He tells you he will help, he needs to go right now or else he will be incontinent. What will you do?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip or film.

2. Show students equipment used for transfers.

LESSON PLAN: 55

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

EVALUATION ITEMS:

1. Describe two methods of active assistive transfer.

   a.

   b.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 2. Wheelchairs or geri chairs should have locks which are locked during the transfer.

_____ 3. The client who can only give minimal assistance should not be given explanations since he/she will not be helping anyway.

_____ 4. If you are a strong person, you should be able to transfer any client, even one who cannot bear any of his/her own body weight.

_____ 5. The position of the footrests is not significant when transferring clients.

_____ 6. Have all equipment handy before beginning the procedure and check it for safety.

7. Which of the following equipment cannot be used for transfer? (Circle the letter of the correct answer.)

   a. Transfer belt
   b. Hydraulic lift
   c. Sliding board
   d. Footboard

8. Which of the following areas of the body should be checked for proper body alignment when the client is positioned in a chair? (Circle the letter of the correct answer.)

   a. Head

   b. Hips and buttocks

   c. Feet

   d. All of the above

9. You are caring for a client, she is sitting in a chair but has slid forward and is out of body alignment and appears to be uncomfortable. How will you reposition her?

LESSON PLAN: 55

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:
   a. Sitting transfer - client remains in sitting position when transferred
   b. Standing transfer - client stands and pivots or takes steps to transfer
      1. Chair to bed; bed to chair
      2. Chair to ambulation device
   c. Lying transfer
      1. Bed to stretcher; stretcher to bed
      2. Using a hydraulic lift
2. T
3. F
4. F
5. F
6. T
7. d
8. d
9. Apply transfer belt. Stand behind chair and put arms under client's upper arms and grasp the client's wrists in front of the client's chest (her arms should be folded in front of her chest). On the count of three pull the client up and back into the chair. If the client can help, have her push with her feet on the footrests.

LESSON PLAN: 56

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: OR DEMONSTRATION: VIII-56

TRANSFER ACTIVITIES
(Lesson Title)

LESSON OBJECTIVES THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to transfer a client from the bed to chair according to the steps of procedure.
2. Demonstrate how to transfer a client from chair to bed according to the steps of procedure.
3. Demonstrate how to use a hydraulic lift to transfer a client according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Bed
2. Chair
3. Hydraulic lift

LESSON PLAN: 56

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING

STEPS OF PROCEDURE:

Transfer From Bed to Chair with Client Assistance

Steps beginning procedure

1. Wash your hands
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. When possible, adjust bed height to low position. Lock brakes of bed.

Procedure for bed to chair transfer with client assistance

7. May raise head of bed to bring client to sitting position.
8. Assist client to move over in bed to within five or six inches of the edge of the bed.
9. Position nurse assistant's body facing foot of bed.
10. Put one forearm under client's shoulders and the other behind the knees.
11. Bend your knees; keep back straight and stand with feet apart about 18 inches.
12. Straighten your hips and knees, while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over side of bed with other arm.
13. Allow the client time for his/her circulation to adjust to being in a sitting position before you proceed.
14. Assist in putting on socks and nonskid shoes; apply transfer belt.

15. Position wheelchair or geri chair or commode on strong side if indicated, if not, position chair as desired.

16. Place chair parallel to or at a 45° angle to the bed.

17. Lock the wheels of the chair.

18. Cover wheelchair or geri chair with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the arm rest on the side next to the bed.

19. Place hands underneath belt along the client's side with palms up; if a belt is not available place your arms under client's armpits.

20. Instruct client to stand on the count of three.

21 Assist client to stand and support the weak leg with your knee if indicated.

22. Instruct client to reach with his/her strong hand and grasp for the far armrest of the chair.

23. Assist the client to pivot toward the strong leg by turning your own body. Do not twist--turn your body as a unit.

24. Gently assist client to sit by bending your knees and keep back straight.

Steps ending procedure

25. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.

26. Secure a restraint to the chair if ordered by the physician and if necessary for client's safety.

27. Wash your hands.

Transfer Helpless Client From Bed to Chair

Steps beginning procedure

1-6. If client is totally helpless, get someone to help you. See steps 1 through 6 of transfer from bed to chair with client assistance procedure.

Procedure for bed to chair transfer of helpless client

7. May raise head of bed to bring client to sitting position.

8. Assist client to move over in bed to within five or six inches of the edge of the bed.

9. Assist in putting on socks and nonskid shoes, apply transfer belt.

10. Position wheelchair or geri chair or commode on client's strong side if indicated, if not, position chair as desired.

11. Place chair parallel to or at a 45 degrees F. angle to the bed.

12. Lock the wheels of the chair.

13. Cover wheelchair or geri chair with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.

14. Position your body so you are facing the foot of the bed.

15. Put one forearm under client's shoulders and the other behind the knees.

16. Bend your knees; keep back straight and stand with feet apart about 18 inches.

17. Straighten your hips and knees, while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over side of bed with other arm.

18. Allow the client time for his/her circulation to adjust to being in a sitting position before you proceed.

19. Stand directly in front of the client, grasp the back of the belt. If a belt is not available, place your arms under the client's armpits.

20. Support the client's knees and feet with your knees and feet, either knee-to-knee or your knees on the sides of the client's knees, whatever is comfortable for you and the client.

21. Have the client lean forward while sitting on the edge of the bed.

22. On the count of three have the client push up as much as possible while you pull him/her up by straightening your legs and hips and holding onto the belt or under arms of client.

23. Pivot your entire body as well as the client's.

24. Lower the client into the chair by bending at your knees and hips as the client sits down; if possible, the client can grasp the arm of the chair to help support his/her weight while sitting down.

Steps ending procedure

25. Adjust footrest for client; cover with a lap robe.

26. Position pillow(s) to provide proper body alignment and joint support.

27. Make the client comfortable; place call signal within reach.

28. Wash your hands.

Using a Hydraulic Lift

Steps beginning procedure

1-6. See steps 1 through 6 of transfer from bed to chair with client assistance procedure.

NOTE: This procedure will always require two persons to accomplish the transfer safely.

Steps for using the hydraulic lift

7. Position chair next to bed with the back of chair in line with the headboard of the bed.

8. By turning the client from side to side on the bed, slide the sling under the client.

NOTE: Make sure the top of the sling is at the crest of the shoulders and the bottom is above the bend of the knees.

9. Wheel the lift into place over the client with the base beneath the bed and be sure to lock the wheels of the lift.

10. Attach the sling to the hydraulic lift with the hooks in place under the metal frame.

    NOTE: Be sure to apply hooks with open, sharp ends away from the client.

11. Have the client fold both arms across chest, if possible.

12. Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.

13. One of the nurse assistants should guide the client's legs over the edge of the bed; release brakes on hydraulic lift.

14. Move the lift away from the bed, turn the client so that he/she faces you while the other nurse assistant guides the client's body toward the chair by standing behind the client.

15. Open the support legs of the lift with the control lever then bring the lift into position so that the client is over the seat of the chair.

16. Release the control knob slowly so that the client will gradually be lowered into chair but not be pulled backwards.

17. Remove the hooks from the frame of the lift.

Steps ending procedure

18. Cover client with lap robe

19. Secure the client to the chair with safety restraint if ordered and necessary.

20. Make the client comfortable; place call signal within reach.

21. Wash your hands.

22. Store lift properly until time to transfer client again.

SUMMARY AND CONSLUSION:

1. Ask classroom discussion items.

2. Review steps of procedures.

LESSON PLAN: 56

COURSE TITLE: NURSE ASSISTANT

UNIT VIII: RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. If the client has a weak side, where should you position the wheelchair or geri chair?
2. What safety precautions must you take when transferring a client from chair to bed?
3. Why is it necessary to allow the client to sit a minute after changing his/her position from supine to sitting?
4. In which direction should the hooks of the hydraulic lift that fit into the sling be turned?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates how to transfer a client from bed to chair and chair to bed, and the use of the hydraulic lift.
2. Students practice transferring each other from bed to chair and chair to bed. Also use hydraulic lifting device if available.

LESSON PLAN: 56

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS: NAME OF STUDENT________________

TRANSFER ACTIVITIES

EQUIPMENT

1. Bed
2. Chair
3. Hydraulic Lift

DID THE STUDENT	YES	NO
Transfer From Bed to Chair with Client Assistance		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
6. When possible, adjust bed height to low position. Lock brakes of bed.		
B. Procedure for bed to chair transfer with client assistance.		
7. May raise head of bed to bring client to sitting position.		
8. Assist client to move over in bed to within five or six inches of the edge of the bed.		

2. Crutch tips are attached to the crutches. They must not be worn down or cracked.

3. Crutches must be checked for flaws, such as cracks in wooden crutches and bends in aluminum crutches. Bolts should be tight.

4. Street shoes with flat, non skid soles should be worn.

5. The height of the crutches is adjusted by the nurse or physical therapist. A proper fitted crutch will prevent injury to the client's underarms and palms.

	YES	NO
9. Position NA's body facing foot of bed.		
10. Put one forearm under client's shoulders and the other behind the knees.		
11. Bend knees; keep back straight and stand with feet apart about 18 inches.		
12. Straighten hips and knees, while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over side of bed with other arm.		
13. Allow the client time for his/her circulation to adjust to being in a sitting position before proceeding with transfer.		
14. Assist in putting on socks and nonskid shoes; apply transfer belt.		
15. Position wheelchair or geri chair or commode on client's strong side if indicated, if not, position chair as desired.		
16. Place chair parallel to or at a 45 degree F. angle to the bed.		
17. Lock the wheels of the chair.		
18. Cover wheel chair or geri chair with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible, remove the armrest on the side next to the bed.		
19. Place hands underneath belt along the client's side with palms up; if a belt is not available place arms under client's armpits.		
20. Instruct client to stand on the count of three.		

	YES	NO
21. Assist client to stand and support the weak leg with knee if indicated.		
22. Instruct client to reach with his/her strong hand and grasp for the far armrest of the chair.		
23. Assist the client to pivot toward the strong leg.		
24. Gently assist client to sit by bending knees and keeping back straight.		
C. Steps ending procedure 25. Position the weak arm and leg properly on the armrest and footrest. A pillow may be used to support the weak arm.		
26. Secure a restraint to the chair if ordered by the doctor and if necessary for client's safety.		
27. Wash hands.		
Transfer Helpless Client From Bed to Chair A. Steps beginning procedure 1-6. Complete steps 1 through 6 of transfer from bed to chair with client assistance procedure.		
B. Procedure for bed to chair transfer of helpless client 7. May raise head of bed to bring to sitting position.		
8. Assist client to move over in bed to within five or six inches of the edge of the bed.		
9. Assist in putting on socks and nonskid shoes; apply transfer belt.		
10. Position wheelchair or geri chair or commode on client's strong side if indicated, if not, position chair as desired.		

	YES	NO
23. Pivot entire body as well as the client's.		
24. Lower the client into the chair by bending at knees and hips as the client sits down; if possible, the client can grasp the arm of the chair to help support his/her weight while sitting down.		
C. Steps ending procedure 25. Adjust footrest for client; cover with a lap robe.		
26. Position pillow(s) to provide proper body alignment and joint support.		
27. Make the client comfortable; place call signal within reach.		
28. Wash hands.		
Using a Hydraulic Lift A. Steps Beginning Procedure 1-6. Complete steps 1 through 6 of transfer from bed to chair with client assistance procedure		
B. Procedure for using hydraulic lift 7. Secure assistance of another nurse assistant.		
8. Position chair next to bed with the back of chair in line with the headboard of the bed.		
9. By turning the client from side to side on the bed, slide the sling under the client and position it properly at shoulders and knees.		
10. Wheel the lift into place over the client with the base beneath the bed and be sure to lock the wheels of the lift.		

	YES	NO
11. Attach the sling to the hydraulic lift with the hooks in place under the metal frame.		
12. Have the client fold both arms across chest, if possible.		
13. Using the crank, lift the client until the buttocks are clear of the bed. Make sure the client is aligned in the sling and is securely suspended in a sitting position with legs dangling over the bottom of the sling.		
14. One of the nurse assistants should guide the client's legs over the edge of the bed; release brakes on hydraulic lift.		
15. Move the lift away from the bed, turn the client so that he/she faces one nurse assistant while the other guides the client's body toward the chair by standing behind the client.		
16. Open the support legs of the lift with the control lever then bring the lift into position so that the client is over the seat of the chair.		
17. Release the control knob slowly so that the client will gradually be lowered into chair but not be pulled backwards.		
18. Remove the hooks from the frame of the lift.		
C. Steps ending procedure 19. Cover client with lap robe.		
20. Secure the client to the chair with safety restraint if ordered and necessary.		
21. Make the client comfortable; place call signal within reach.		

	YES	NO
22. Wash hands.		
23. Store lift properly until time to transfer client again.		

The student has satisfactorily completed the procedure "TRANSFER ACTIVITIES" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: VIII-57 OR DEMONSTRATION: VIII-57

AMBULATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List three purposes of ambulation
2. Identify four nursing responsibilities when assisting the client with ambulation.
3. Recognize four types of equipment that may be used to assist with ambulating a client.
4. Demonstrate how to ambulate a client using a gait belt according to the steps of procedure.
5. Demonstrate how to ambulate a client using a walker according to the steps of procedure.
6. Demonstrate how to ambulate a client using a cane according to the steps of procedure.
7. Demonstrate how to ambulate a client using crutches.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Gait belt
2. Walker
3. Cane
4. Brace
5. Prosthesis
6. Crutches
7. Filmstrip or film

TEACHER RESOURCES:

INTRODUCTION:

Ambulation means walking or moving around in an upright position. Ambulating a client correctly is a skill that a nursing assistant must develop in order to help the client remain physically active and to prevent complications of extended bed rest.

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

OUTLINE: (Key Points)

I. Purposes of Ambulation

  A. Keeps the client more active

  B. Improves muscle tone in legs; improves strength

  C.. Provides sense of accomplishment

  D. Allows client to maintain greater independence

II. Nurse Assistant Responsibilities in Ambulating Clients

  A. Be aware of safety considerations - make sure objects and other clients are out of the way; no slippery floors or shoes; suction tips on all equipment.

  B. Use good body mechanics.

  C. Dress client appropriately.

  D. Observe client's ambulation and response to ambulation (i.e., steadiness of gait, balance and endurance).

  E. Ambulate client in an uncluttered area. Have a chair ready for the client at the other end, or at a resting point along the way.

  F. Most of the time, you will ambulate at the client's side, with your arm/hand for support--standing on the client's strongest side. If the client is to be encouraged to use a weak leg, stand on the weak side.

III. Equipment Used for Ambulation

  A. Transfer or gait belt

    1. Grasp the belt with both hands and use it to guide the client.

    2. Walk slowly and allow the client to set the pace.

B. Walker

1. Used for client who requires some support when walking due to imbalance or weakness.

2. Client may be able to bear weight on one foot; remain balanced in an upright position and have use of hands and arms.

3. When walker is being moved, the client's feet should not be moving. It should never be slid along the floor or ground.

4. The height of the walker should be adjusted so that the client is standing straight with elbows slightly flexed.

C. Cane

1. Used for clients who have weakness or paralysis on one side of the body.

2. Should be used on client's stronger side to balance his/her weight between the cane and his/her weaker side.

3. The height of the cane should be such that the client holds it with his/her elbow slightly bent when walking.

D. Brace

1. Used for clients who need specific support for weakened muscles/joints or to provide immobilization of an injured part.

2. Never loosen screws/bolts of brace; check skin where brace is applied for any signs of breakdown.

3. Prop brace when not in use. Never lay it flat--it could warp.

E. Prosthesis - artificial limb

1. Used for client who is missing an arm/leg

2. Check skin of stump for any signs of breakdown; see that prosthesis fits.

F. Crutches

1. Used for residents who are not able to use one leg or when one or both legs have temporary or permanent weakness.

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

IV. Steps of Procedure for Ambulation With a Gait Belt

A. Steps beginning procedure

1. Wash your hands
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Lower bed to lowest level; assist client to sit on edge of bed.
5. Pause and allow client to sit on edge of bed a few moments to regain balance.
6. Assist client in putting on nonskid shoes and socks.
7. Put gait belt around client's waist.
8. Stand in position of good body mechanics.
9. Assist the client to a standing position.

B. Ambulation procedure (gait belt)

10. Assist client to stand by straightening legs as you lift with gait belt as client pushes down with hands on the mattress.
11. Pause to allow client to regain balance.
12. Walk with the client by placing one hand around the back of his/her waist and the other hand under the gait belt; walk on the weakest side and encourage client to hold handrail, if available, with strong arm.
13. Walk in the same pattern as the client (both step with left foot at the same time, assist client to step forward with strong foot first).

	YES	NO
11. Place chair parallel to or at a 45 degree angle to the bed.		
12. Lock the wheels of the chair.		
13. Cover wheelchair or geri chair with bath blanket and/or protective pad. Raise footrests and remove if possible. If possible remove the armrest on the side next to the bed.		
14. Position NA's body facing foot of bed.		
15. Put one forearm under client's shoulders and the other behind the knees.		
16. Bend knees; keep back straight and stand with feet apart about 18 inches.		
17. Straighten hips and knees, while shifting weight from front foot to back foot. At the same time, lift client's head-neck with one arm while pulling the legs over side of bed with other arm.		
18. Allow the client time for his/her circulation to adjust to being in a sitting position before proceeding with the transfer.		
19. Stand directly in front of the client, grasp the back of the belt. If a belt is not available, place arms under the client's armpits.		
20. Support the client's knees and feet.		
21. Have the client lean forward while sitting on the edge of the bed.		
22. On the count of three have the client push up as much as possible while pulling him/her up by straightening legs and hips and holding onto the belt or under arms of client.		

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS: NAME OF STUDENT ______________________

AMBULATION

EQUIPMENT:

1. Gait belt
2. Walker
3. Cane
4. Crutches

DID THE STUDENT	YES	NO
Ambulation With Gait Belt		
A. Steps beginning procedure		
1. Wash hands.		
2. Identify and greet client. Identify self.		
3. Explain procedure to client.		
4. When possible, lower bed to lowest level; assist client to sit on edge of bed.		
5. Pause and allow client to sit on edge of bed a few moments to regain balance.		
6. Assist client in putting on nonskid shoes and socks.		
7. Put gait belt around client's waist.		
8. Stand in position of good body mechanics.		
9. Assist the client to a standing position.		

	YES	NO
B. Ambulation procedure (gait belt)		
10. Assist client to stand by straightening legs while lifting with gait belt as client pushes down with hands on the mattress.		
11. Pause to allow client to regain balance.		
12. Walk with the client by placing one hand around the back of his/her waist and the other hand under the gait belt; walk on the weakest side and encourage client to hold handrail, if available, with strong arm.		
13. Walk in the same pattern as the client (both step with left foot at the same time, assist client to step forward with strong foot first.)		
14. Walk client the distance instructed by charge nurse.		
C. Steps ending procedure 15. Return client to bed/chair.		
16. Make sure client is comfortable; place call signal within reach.		
17. Remove gait belt.		
18. Wash hands.		
19. Record observations.		
Ambulation With Walker A. Steps beginning procedure 1-9. Complete steps 1 through 9 of ambulate with gait belt procedure.		

	YES	NO
B. Ambulation procedure (walker)		
10. Instruct client to position body within the frame of the walker.		
11. Instruct client to move walker forward by lifting it up.		
12. Instruct client to take a step forward with the weak leg.		
13. Instruct client to then move strong leg forward.		
14. Repeat steps 10 through 13 to distance instructed by charge nurse.		
15. To ambulate backward (to sit down in chair), client steps back with strong foot, takes a step back with weak foot, then walker is moved back. Have client feel for arms of chair with his/her hand.		
C. Steps ending procedure		
16-20. Complete steps 15 through 19 of ambulate with gait belt procedure.		
Ambulation With Cane		
A. Steps beginning procedure		
1-9. Complete steps 1 through 9 of ambulate with gait belt procedure.		
B. Ambulation procedure (cane)		
10. Instruct client to take short steps and keep head up and eyes looking forward.		
11. Instruct client to move cane forward and a little out to the side of the strong leg.		
12. Instruct client to move weak extremity forward to line even with tip of cane just after cane is placed.		

	YES	NO
13. Instruct client to put weight on cane and weak foot while swinging strong foot forward, taking a step.		
14-17. Repeat steps 10 through 13 to distance instructed by charge nurse.		
C. Steps ending procedure 18-22 Complete steps 15 through 19 of ambulate with gait belt procedure.		
Ambulation with Crutches A. Steps beginning procedure 1-9 Complete steps 1 through 9 of ambulate with gait belt procedure.		
B. Ambulation Procedure (Crutches) 10. Instruct client to position crutches under his/her arms applying weight to the crutches through hands and arms.		
11. Instruct client to stand with shoulders, back and head erect, pelvis situated directly over feet.		
12. Instruct client to use entire foot for walking.		
13. Instruct client to begin all gaits from tripod position. The crutches are placed 8-10" to front and side of client's toes.		
14. Four Point Gait: Client advances crutch on his/her strong side, opposite his/her weak foot.		
15. He/she advances his/her weak foot to a position in line with that crutch.		
16. He/she then advances crutch on his/her weak side to a position beyond the other crutch.		

15. He/she then advances his/her weak foot to a position in line with that crutch.

16. He/she then advances crutch on his weak side to a position beyond the other crutch.

17. Then the client advances his strong foot in line with that crutch.

18-21 Repeat steps 14 through 17 to distance instructed by charge nurse.

C. Steps ending procedure

22-25 See steps 15 through 19 of ambulate with gait belt procedure.

VIII. Summary and Conclusion

A. Purposes of ambulation

B. Nurse assistant responsibilities in ambulating

C. Equipment used for ambulation

D Classroom Discussion.

E. Review steps of procedure.

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. Why is it important to ambulate the client?
2. Why does the client need stockings and nonskid shoes in order to prepare for ambulation?
3. Why do you pause and allow client to sit on edge of bed before starting ambulation?
4. How should you walk when ambulating a client?
5. How far should the client ambulate?
6. What is the procedure for lowering a client to the floor if he/she loses his/her weight-bearing ability?
7. How should the client be instructed to move the walker forward?
8. On which side should the client hold the cane?
9. What is the position of good body mechanics when assisting a client to standing position?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates ambulation procedures using gait belt, walker, cane and crutches.
2. Students practice ambulating one another with gait belt, walker, cane and crutches.
3. Show filmstrip or film.

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS:

1. List three purposes of ambulation:

   a.

   b.

   c.

2. Which of the following is not a device used to assist with ambulation? (Circle the letter of the correct answer.)

   a. Walker
   b. Cane
   c. Gait belt
   d. Wheelchair

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 3. When ambulating a client, body mechanics are not important to remember.

_____ 4. Always make sure objects are out of the way before starting to ambulate a client.

_____ 5. If a client is to be encouraged to use his/her weak leg more, stand on the strong side.

_____ 6. The client should be dressed in his/her pajamas when ambulating in the hall.

LESSON PLAN: 57

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

ANSWERS TO EVALUATION ITEMS:

1. The student may list any three of the following:
    a. Keeps the client more active
    b. Improves muscle tone in legs; improves strength
    c. Provides sense of accomplishment
    d. Allows client to maintain greater balance
2. d
3. F
4. T
5. F
6. F

	YES	NO
17. Then the client advances his/her strong foot in line with that crutch.		
18-21. Repeat steps 14 through 17 to distance instructed by charge nurse.		
C. Steps ending procedure 22-25 Complete steps 15 through 19 of ambulate with gait belt procedure.		

The student has satisfactorily completed the procedure "AMBULATION" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

SCOPE OF UNIT:

This unit includes information to prepare the nurse assistant to play a supportive role in restorative nursing. Other lessons are: body mechanics; lifting and moving; positioning; principles of transfer; transfer activities; ambulation; and range of motion exercises.

INFORMATION TOPIC: VIII-58 OR DEMONSTRATION: VIII-58

RANGE OF MOTION EXERCISES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. March terms presented in this lesson to correct definitions.
2. Give range of motion exercises according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Range of Motion Exercises
2. Filmstrip or film.
3. Projector
4. Hospital bed made up with linens.

TEACHER RESOURCES:

INTRODUCTION:

Range of motion exercises are given to move the joints of the body through their normal movements. These exercises are given to prevent stiffness, deformities, and to maintain muscle strength. When doing these exercises, work slowly and smoothly; don't exercise a joint past the point of pain/resistance. Always support an extremity at the joint by cupping with your hand. Never grasp the muscle as this can be painful. Encourage the client to do as much as possible. Do the exercises as many times as instructed by the charge nurse. In addition to the physical advantages, clients often express appreciation for the relaxing effects that result from range of motion exercises. The following procedure covers a logical sequence so that each joint and muscle is exercised.

14. Walk client the distance instructed by charge nurse...

    NOTE: If client loses weight-bearing ability, pull the client's body into close alignment with your hip/thigh area by using the gait belt and lower to floor using large muscles of your legs.

C. Steps ending procedure

15. Return client to bed/chair.

16. Make sure client is comfortable; place call signal within reach.

17. Remove gait belt.

18. Wash your hands.

19. Record observations.

V. Steps of Procedure for Ambulation With Walker

A. Steps beginning procedure

1-9 See steps 1 through 9 of ambulate with gait belt procedure.

B. Ambulation procedure (walker)

10. Instruct client to position body within the frame of the walker.

11. Instruct client to move walker forward by lifting it up.

12. Instruct client to take a step forward with the weak leg.

13. Instruct client to then move strong leg forward.

14. Repeat steps 10 through 13 to distance instructed by charge nurse.

15. To ambulate backward (to sit down in chair), client steps back with strong foot, takes a step back with weak foot, then walker is moved back. Have client feel for arms of chair with his/her hand.

C. Steps ending procedure

16-20. See steps 15-19 of ambulate with gait belt procedure.

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

I. Terms and Definitions

A. Abduction - away from the center of the body

B. Adduction - toward the center of the body

C. Extension - to straighten

D. External Rotation - to turn out away from center

E. Flexion - to bend

F. Hyperextension - extensive extension

G. Internal rotation - to turn in toward center

H. Lateral - to the side

I. Pronation - to turn downward or backward

J. Rotation - to move a joint in a circular motion

K. Supination - to turn upward or forward

VI. Steps of Procedure for Ambulation with Cane

A. Steps beginning procedure

1-9. See steps 1 through 9 of ambulate with gait belt procedure.

B. Ambulation procedure (cane)

10. Instruct client to take short steps and keep head up and eyes looking forward.

11. Client moves cane forward and a little out to the side of the strong leg.

12. Client moves weak extremity forward to line even with tip of cane just after cane is placed.

13. Instruct client to put weight on cane and weak foot while swinging strong foot forward, taking a step.

14-17. Repeat steps 10 through 13 to distance instructed by charge nurse.

C. Steps ending procedure

18-22 See steps 13 through 19 of ambulate with gait belt procedure

VII. Steps of Procedures for Ambulation With Crutches (4 Point Gait)

A. Steps beginning procedure

1-9. See steps 1 through 9 of ambulate with gait belt procedure.

B. Ambulation Procedure

10. Instruct client to position crutches under his/her arms applying weight to the crutches through his hands and arms.

11. Instruct client to stand with shoulders back and head erect, pelvis situated directly over feet.

12. Instruct client to use entire foot for walking.

13. Instruct client to begin all gaits from tripod position. The crutches are placed 8-10" to front and side of client's toes.

14. Four point gait - Client advances the crutch on strong side, opposite weak foot.

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING:

ANSWERS TO EVALUATION ITEMS:

1. b
2. i
3. e
4. a
5. d
6. c
7. g
8. f
9. h
10. k
11. j

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

EVALUATION ITEMS: NAME OF STUDENT: ____________________

RANGE OF MOTION EXERCISES

EQUIPMENT:

1. Hospital bed made up with linens

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Identify and greet client. Identify self.		
3. Explain what he/she is going to do.		
4. Provide privacy--make sure client is wearing adequate clothing.		
5. When possible, raise bed to a comfortable working height.		
6. Assist client into supine position.		
B. Procedures for range of motion exercises		
7. Neck		
a. Flexion/extension		
1. Supporting head with hands, bend head forward trying to touch the chest with the chin.		
2. Bring head back to pillow.		
b. Right and left rotation - turn head from side to side.		

	YES	NO
8. Shoulders a. Flexion/extension 1. Supporting the arm at the wrist and elbow, lift the arm toward the ceiling, continue lifting over the client's head until resistance is felt.		
2. Slowly lower the arm to the client's side.		
b. Abduction/adduction 1. Supporting the arm at the elbow and shoulder, move the arm out to the side, continue moving toward client's head.		
2. Slowly move the arm back toward the center of the body.		
c. Internal/external rotation 1. Move the arm away from the body to shoulder level.		
2. Bring the hand forward to touch the bed and then backward to touch the bed.		
9. Elbow a. Flexion/extension 1. Bend the arm at the elbow and touch the shoulder, then straighten the arm.		
2. Bend the arm at the elbow and touch the chin, then straighten the arm.		
b. Pronation/supination 1. Hold the client's hand in a handshake position; support the arm at the elbow joint.		

	YES	NO
2. Turn palm of the hand toward floor and then away from the floor.		
10. Wrist a. Flexion/extension/hyperextension - support arm and hand; bend the wrist forward, straighten and then bend it backward.		
b. Abduction/adduction - move the hand from side to side at the wrist.		
11. Fingers a. Flexion/extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct client to make a clenched fist and then relax it.		
b. Abduction/adduction - move each finger away from the nearest finger and then return it.		
c. Thumb opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.		
d. Thumb rotation - move the thumb in a circle one direction and then the other direction.		
12. Hip and knee a. Flexion/extension 1. Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.		
2. Bend the knee and move toward the chest, slowly straighten the knee.		

	YES	NO
b. Abduction/adduction 1. Move the leg straight out to the side of the body until resistance is felt.		
2. Slowly move the leg back toward the center of the body.		
c. Internal/external/rotation - support the knee and ankle joints; move the ankle in toward the opposite leg and then outward.		
13. Ankle a. Inversion/eversion - supporting the foot at the ankle joint, turn the foot toward the opposite foot and then away from the opposite foot.		
b. Dorsiflexion/plantarflexion - bend the foot up toward the knee, then down toward the floor.		
14. Toes a. Flexion/extension - bend and then straighten the toes.		
b. Abduction/adduction - move each toe toward the next toe, and then away from the next toe.		
C. Steps ending procedure 15. Lower bed to a position of safety; raise side rails where ordered.		
16. Make the client comfortable; place call signal within reach.		
17. Wash hands.		

The student has satisfactorily completed the procedure "RANGE OF MOTION EXERCISES" according to the steps outlined.

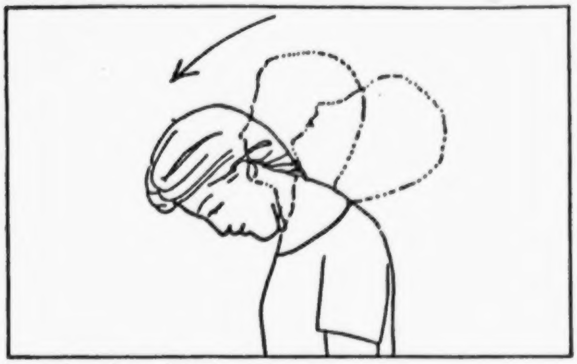
Instructor's signature
(Verifying Satisfactory Completion)

Date

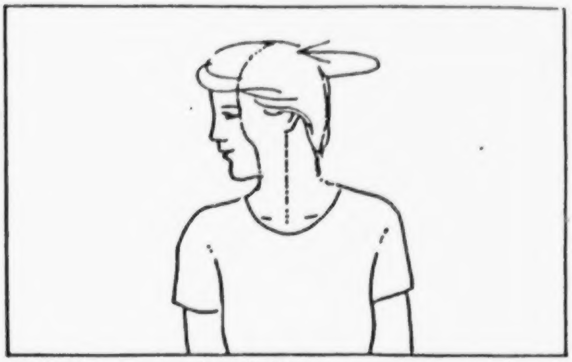
RANGE OF MOTION EXCERCISES

HO 1

NECK

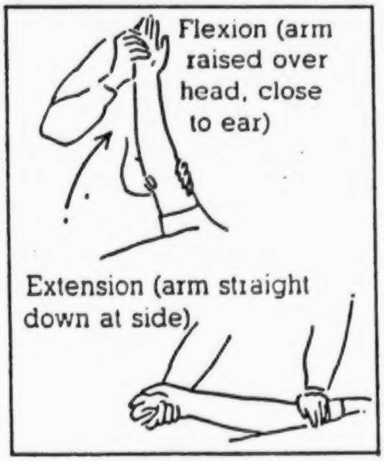


1. Flexion/Extension



2. Right and Left Rotation

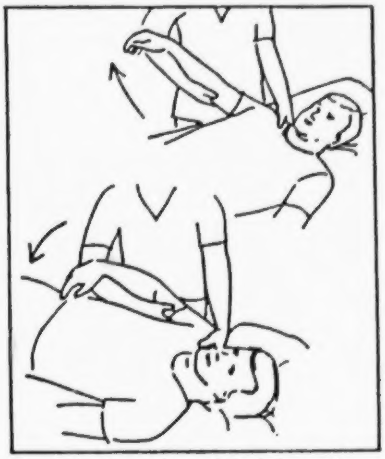
SHOULDERS



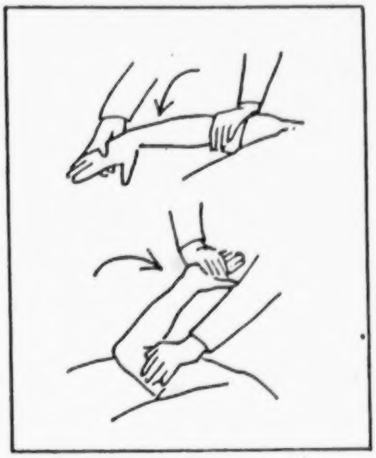
Flexion (arm raised over head, close to ear)

Extension (arm straight down at side)

1. Flexion/Extension

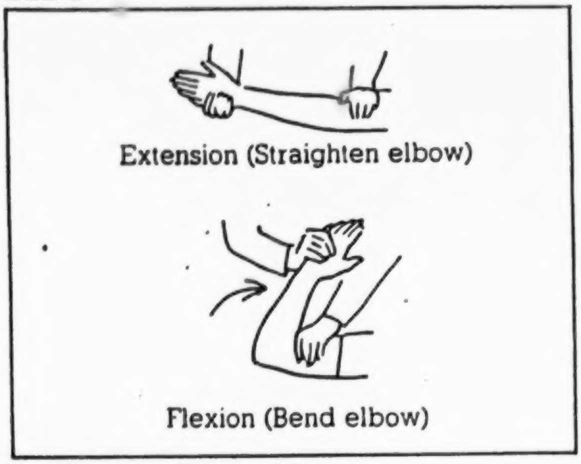


2. Abduction/Adduction



3. Internal/External Rotation

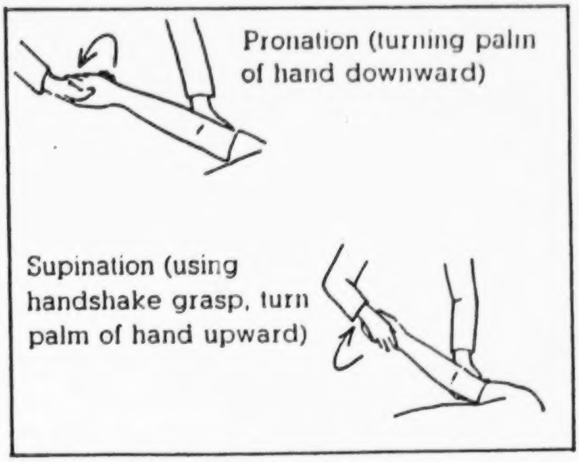
ELBOW



Extension (Straighten elbow)

Flexion (Bend elbow)

1. Flexion/Extension

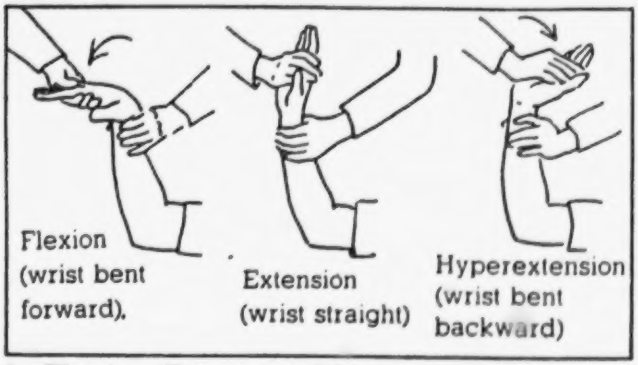


Pronation (turning palm of hand downward)

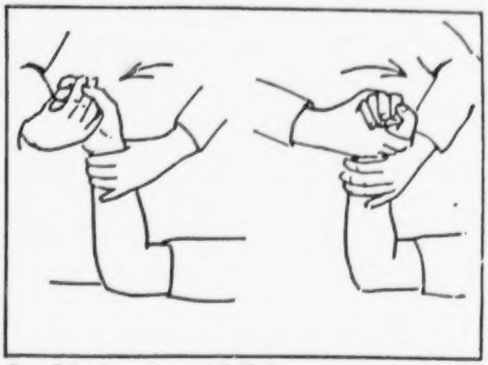
Supination (using handshake grasp, turn palm of hand upward)

2. Pronation/Supination

WRIST

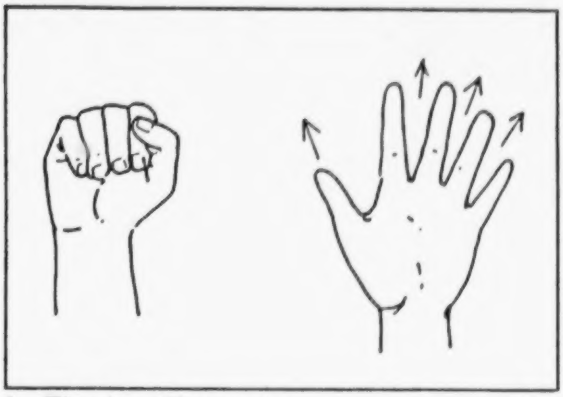

Flexion (wrist bent forward).
Extension (wrist straight)
Hyperextension (wrist bent backward)

1. Flexion/Extension/Hyperextension

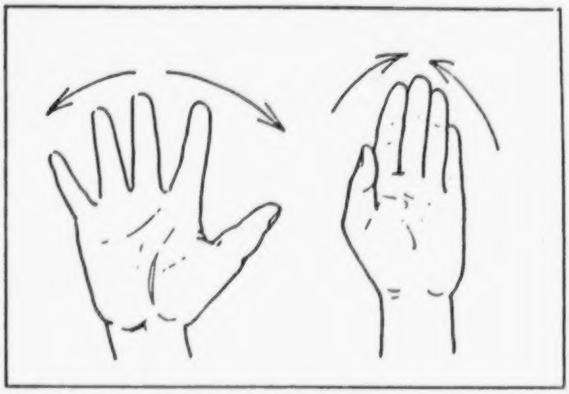


2. Abduction/Adduction

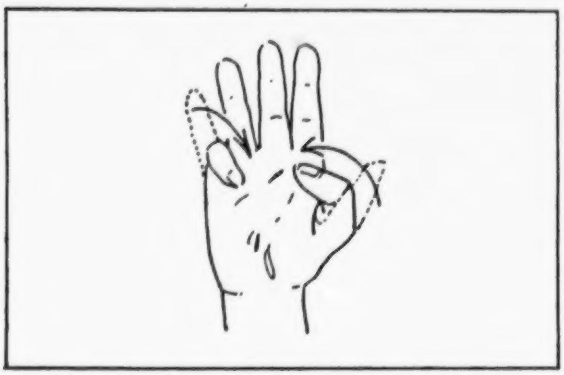
FINGERS



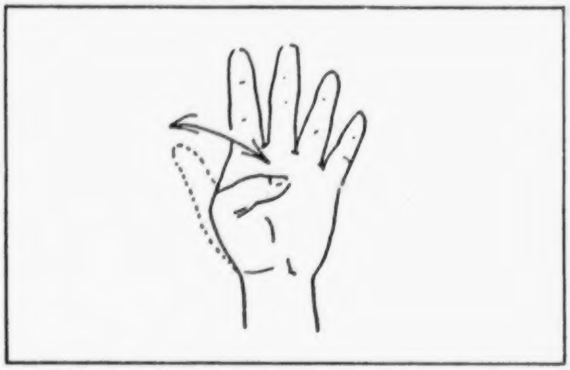
1. Flexion/Extension



2. Abduction/Adduction

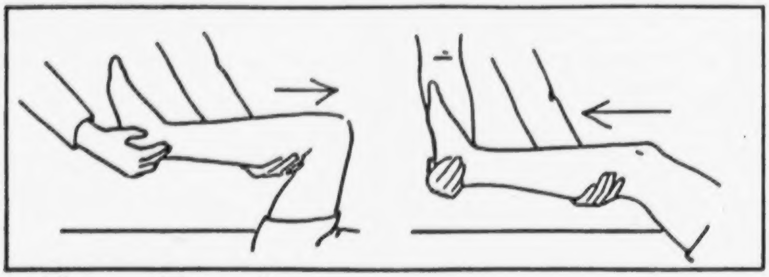


3. Thumb Opposition

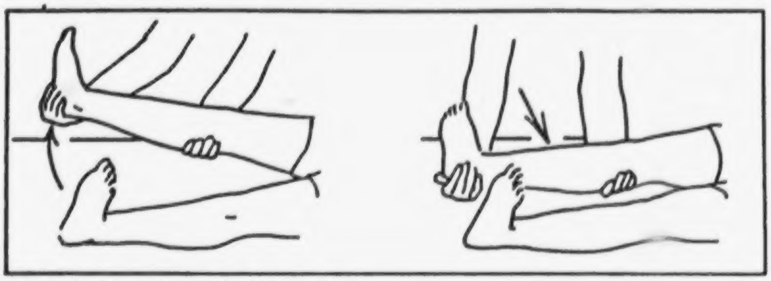


4. Thumb Rotation

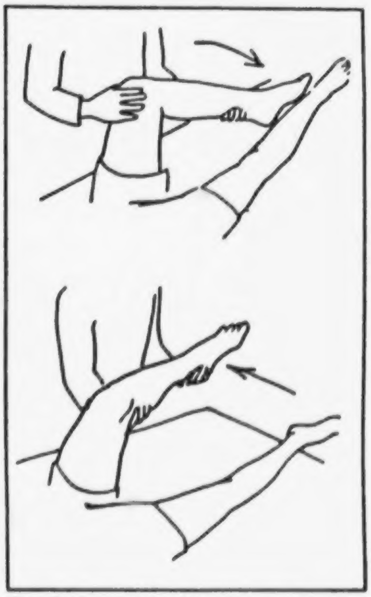
HIPS AND KNEE



1. Flexion/Extension

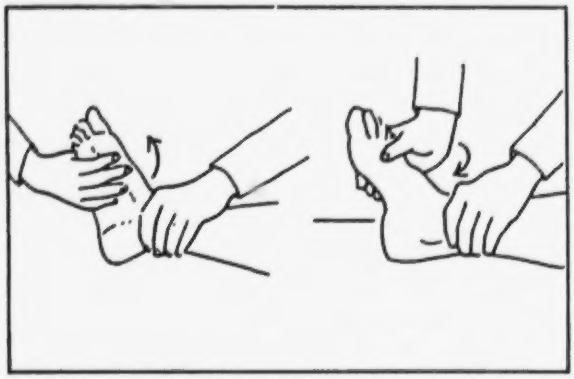


2. Abduction/Adduction

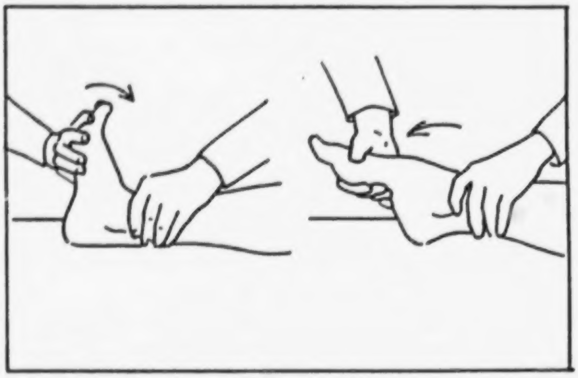


3. Internal/External Rotation

ANKLE

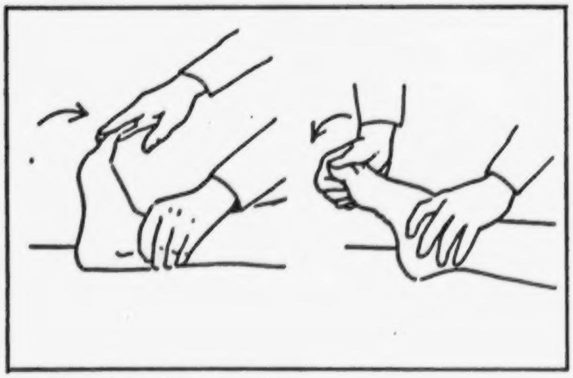


1. Inversion/Eversion

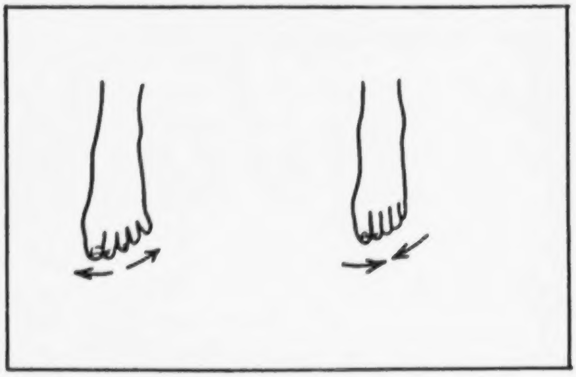


2. Dorsiflexion/Plantarflexion

TOES



1. Flexion/Extension



2. Abduction/Adduction

b. Abduction/adduction

1. Supporting the arm at the elbow and shoulder, move the arm out to the side, continue moving toward client's head.

2. Slowly move the arm back toward the center of body.

c. Internal/external rotation

1. Move the arm away from the body to shoulder level.

2. Bring the hand forward to touch the bed and then backward to touch the bed.

9. Elbow

a. Flexion/extension

1. Bend the arm at the elbow and touch the shoulder then straighten the arm.

2. Bend the arm at the elbow and touch the chin then straighten the arm.

b. Pronation/supination

1. Hold the client's hand in a handshake position; support the arm at the elbow joint.

2. Turn palm of the hand toward floor and then away from the floor.

10. Wrist

a. Flexion/extension/hyperextension - support arm and hand; bend the wrist forward, straighten, and then bend wrist backward.

b. Abduction/adduction - move the hand from side to side at the wrist.

11. Fingers

a. Flexion/extension - support the hand at the wrist; make sure that the thumb is on top of the fingers. Instruct client to make a clenched fist and then relax it.

b. Abduction/adduction - move each finger away from the nearest finger and then return it.

TEACHER RESOURCES:

INTRODUCTION:

Each of you has had to deal with stress during your lifetime, but have you ever had to sell your home and lifelong collection of belongings and move into a strange room, sometimes with another individual? As we age, it becomes more difficult to adjust to new situations. There is an emotional shock and some trauma associated with every change of environment for an older person; therefore, a great deal of reassuring conversation, including explanations, can aid in preventing or softening this shock and trauma.

c. Thumb opposition - bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back.

d. Thumb rotation - move the thumb in a circle one direction and then the other direction.

12. Hip and knee

    a. Flexion/extension

        1. Support the leg at the knee and ankle joints, keep the knee straight; raise and lower the leg.

        2. Bend the knee and move toward the chest, slowly straighten the knee.

    b. Abduction/adduction

        1. Move the leg straight out to the side of the body until you feel resistance.

        2. Slowly move the leg back toward the center of the body.

    c. Internal/external/rotation - support the knee and ankle joints; move the ankle in toward the opposite leg and then outward.

13. Ankle

    a. Inversion/eversion - supporting the foot at the ankle joint, turn the foot toward the opposite foot and then away from the opposite foot.

    b. Dorsiflexion/plantarflexion - bend the foot up toward the knee, then down toward the floor.

14. Toes

    a. Flexion/extension - bend and then straighten the toes.

    b. Abduction/adduction - move each toe toward the next toe and then away from the next toe.

C. Steps ending procedure

15. Lower bed to a position of safety; raise side rails where ordered.

16. Make the client comfortable; place call signal within reach.

17. Wash your hands.

II. SUMMARY AND CONCLUSION

A. Terms and definitions

B. Discuss Classroom Discussion Items

C. Review steps of procedure.

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING:

CLASSROOM DISCUSSION

1. What kind of conditions will range of motion exercises prevent?
2. If a client complains of unusual pain/discomfort, what should you do?
3. What order should you follow when exercising the client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip or film.
2. Instructor demonstrates range of motion exercises.
3. Students practice range of motion exercises on each other.

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

RANGE OF MOTION EXERCISES

EVALUATION ITEMS:

Match the following terms to the correct definition by writing the letter in the blank.

_____ 1. Abduction

_____ 2. Adduction

_____ 3. Extension

_____ 4. External rotation

_____ 5. Flexion

_____ 6. Hyperextension

_____ 7. Internal rotation

_____ 8. Lateral

_____ 9. Pronation

_____10. Rotation

_____11. Supination

a. To turn out away from center

b. Away from the center.

c. Extensive straightening

d. To bend

e. To straighten

f. To the side

g. To turn in toward center

h. To turn downward or backward

i. Toward the center of the body

j. To turn upward or forward

k. To move a joint in a circular motion

LESSON PLAN: 58

COURSE TITLE: NURSE ASSISTANT

UNIT VIII : RESTORATIVE NURSING

I. Steps of Procedure for Range of Motion Exercises

A. Steps beginning procedure

1. Wash your hands
2. Identify and greet client. Identify self.
3. Explain what you are going to do.
4. Provide privacy--make sure client is wearing adequate clothing.
5. When possible, raise bed to a comfortable working height.
6. Assist client into supine position.

B. Procedure for range of motion exercises (HO 1).

7. Neck
    - a. Flexion/extension
        1. Supporting head with hands, bend head forward trying to touch the chest with the chin.
        2. Bring head back to pillow.

           NOTE: Hyperextension is not possible with client in supine position
    - b. Right and left rotation - turn head from side to side.
8. Shoulders
    - a. Flexion/extension
        1. Supporting the arm at the wrist and elbow, lift the arm toward the ceiling, continue lifting over the client's head until you feel resistance.
        2. Slowly lower the arm to the client's side.

LESSON PLAN: 59

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. F

2. T

3. F

4. F

5. T

6. F

VI. Summary and Conclusion

A. Purpose of in-house transfer

B. Nurse assistant's responsibilities in transfer of client

C. Discharge

D. Nurse assistant's responsibilities in the hospital discharge of client

E. Nurse assistant's responsibilities in the discharge of a client to the home or another long-term care facility

Any change of environment can be difficult for the elderly client to accept; it is up to the nursing staff to assist the client in feeling comfortable with that change. Try to reduce the stress and anxiety the client and/or family may be feeling.

LESSON PLAN: 60

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION

1. Why would a client need to be transferred?
2. What kinds of items would you pack for the client who is being discharged to the hospital?
3. When is the facility no longer responsible for the client who is to be discharged?
4. What might be some fears the client may have if being discharged home alone?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Role-play transferring or discharging a client.

LESSON PLAN: 59

COURSE TITLE: NURSE ASSISTANT

UNIT IX: SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing; measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen.

INFORMATION TOPIC: IX-59 OR DEMONSTRATION:

ADMISSION TO A LONG-TERM CARE FACILITY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify feelings the client may have upon admission to a long-term care facility.
2. Recognize the nurse assistant's responsibilities when a client is admitted to a long-term care facility.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Filmstrip - Trainex "Admission to a Long Term Care Facility"
2. Trigger films - Food Shopping
   Food Prep Meal
   Dept. on Aging Loss of Job
   Move From Home "Tagged" - last 5 min. segment
3. Filmstrip projector and 16 mm projector
4. H.O. 1 Admitting Routine Form

LESSON PLAN: 59

COURSE TITLE: NURSE ASSISTANT

UNIT IX: SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Feelings of the Client

  A. May be "upset" about being admitted to a long-term care facility.

  B. Reasons for client's apprehension (CD-1)

    1. Giving up independence and decision-making
    2. Giving up home and lifelong possessions
    3. May feel unsafe and insecure
    4. May feel lonely and abandoned
    5. May feel confused

II. Nurse Assistant's Responsibilities

  A. Prepare the room before the client arrives. (CD-2)

    1. Bed should be made
    2. Room should be neat and clean
    3. Personal care supplies available
    4. Water glass and pitcher at bedside

  B. Greet the client warmly! Ask the client if (CD-2) there is a particular name he/she wishes to be called; don't assume it is acceptable to address the client by his/her first name without first asking.

  C. Introduce yourself to the client and any relatives/ friends who may be present. Explain that you are a nurse assistant who will be assisting the staff nurses in providing care.

  D. Introduce the new client to his/her roommate (if the room is shared).

E. Offer to assist with unpacking and storing belongings; complete a clothes list; make sure all items are marked with the client's name.

F. Explain meal schedules, activities and any other information that pertains to the facility that the client should be told; explain visiting hours.

G. Measure the client's vital signs (TPR & BP), weigh and measure the client.

H. Answer any questions from the client or family members that you are qualified to answer. Refer medical questions to charge nurse.

I. Take the client on a tour of the room and facility. This should include bathroom facilities, nurse's call light, television and/or radio equipment, dining area, visitors' and/or clients' lounge, and location of the nurses' station.

J. Report observations to charge nurse regarding client's physical, emotional, and social conditions

III. Summary and Conclusion

A. Feelings of the client

B. Nurse assistant's responsibilities

As one of the first staff members to meet a new client, you will be making an important first impression--make it a positive one. Gain the trust of the client. Keep in mind that the long-term care facility is the client's new home and try in every way to make him/her feel welcome and happy to be there.

LESSON PLAN: 59

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. How would you feel if you knew the long-term care facility was to be the last place you might live before dying?
2. What can you do to make the experience more pleasant?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Role-play greeting a new client to the facility.
2. Have students write down their feelings about being admitted to a long-term care facility.
3. Role play - fill out Admission Form. Students take turns being client and nurse assistant.

LESSON PLAN: 59

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 1. It is inappropriate for the client to feel unsafe and insecure when admitted to a long-term care facility.

_____ 2. When admitting a client, the nurse assistant should be friendly, call the client by name (that the client prefers) and take the client to his/her assigned room.

_____ 3. Do not introduce the new client to other clients for a few days to avoid confusing him/her.

_____ 4. The meal schedules and activities of the facility should only be explained to the family members.

_____ 5. Introducing yourself and stating that you are a nurse assistant is important for the client to feel welcomed.

_____ 6. Only clients admitted to an acute care center have vital signs measured.

A SAMPLE ADMISSION CHECK LIST

(Fill in every statement and check every appropriate item)

Patient's name ______________________ Room number____

Time of admission __________a.m./p.m. Date of admission __________

Unit ready to receive patient? Yes☐No☐ Equipment ready? Yes☐No☐

Admitted by stretcher________ wheelchair________ walking________

Check identification bracelet? Yes☐No☐ Bed tag in place? Yes☐No☐

Did the patient need help to get undressed? Yes☐No☐

Is the patient in bed at this time? Yes☐No☐ Time________a.m./p.m.

Side rails up? Yes☐No☐

Bruises, marks, rashes, or broken skin noted? Yes☐No☐

If yes, describe ______________________

Weight________ Height________ Scale used? Yes☐No☐

Temperature____ Pulse____ Respirations____ BloodPressure____

Admission urine specimen collected? Yes☐No☐ Sent to lab? Yes☐No☐

Unusual behavior noted? Yes☐No☐ Unusual appearance noted? Yes☐No☐

If yes, describe ______________________

Does the patient have any difficulty with the English language? Yes☐No☐

Is the patient allergic to food? Yes☐No☐ Allergic to drugs? Yes☐ No☐

Reason for admission ______________________

Complaints ______________________

Dentures? Yes☐No☐ Partial? Yes☐No☐ Full? Yes☐No☐ Denture cup? Yes☐No☐

Vision problems? Yes☐No☐ Does the patient wear glasses? Yes☐No☐

Valuables: Money? Yes☐No☐ Describe ______________________

Jewelry? Yes☐ No☐ Describe ______________________

Is the patient hard of hearing? Yes☐No☐ Hearing aid? Yes☐No☐

Artificial limb? Yes☐No☐ Brace? Yes☐No☐

Is the patient calm? Yes☐No☐ Is the patient very anxious? Yes☐No☐

Angry? Yes☐No☐ Is the patient agitated or very excited? Yes☐No☐

Has the patient ever had X rays taken in this hospital before? Yes☐No☐

Has the patient been admitted to this hospital before? Yes☐No☐

Is the clothing list completed? Yes☐No☐ Signed by______________________

Is the signal cord attached to the bed? Yes☐No☐

Have drugs brought into the hospital by the patient been given to the charge nurse? Yes☐No☐

Name of the nurse drugs were given to ______________________

Was the patient told not to eat or drink anything until the doctor's visit? Yes☐No☐

Admitted by ______________________

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-from Brady Being a Nursing Assistant

LESSON PLAN: 60

COURSE TITLE: NURSE ASSISTANT

UNIT IX: SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing' measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-60 OR DEMONSTRATION:

IN-HOUSE TRANSFER OR DISCHARGE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the purpose of an in-house transfer.
2. Recognize the nurse assistant's responsibility in transfer of the client.
3. Define discharge.
4. Identify the nurse assistant's responsibility in discharge of the client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

TEACHER RESOURCES:

INTRODUCTION:

Transfer of the client from one area of a facility to another area can be a positive experience or it may be very stressful, depending on the reason for the transfer. Discharge of the client who is going home can be a very happy and pleasant experience if the client and family are prepared. If the client is to be discharged to the hospital, he/she may be very anxious. Should the client or family express concerns about the transfer or discharge, help them by bringing these concerns to the attention of the charge nurse.

LESSON PLAN: 60

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Purpose of In-House Transfer - to move a client to another area of the facility, usually due to change in the client's condition, incompatability with a roommate, or client's request for accommodation change. (CD-1)

II. Nurse Assistant's Responsibilities in Transfer of Client

   A. Reinforce the nurse's explanation for the reason for the change. (CD-1)

      1. Must be explained to the client in advance of the move, except in an emergency situation.

      2. If the client is confused, the transfer must be explained to a responsible person or relative.

   B. Explain to the client that the transfer is necessary in order to arrange for the best possible care for him/her.

   C. Assist the client to pack and unpack; check valuables and clothing list.

   D. Assist charge nurse in making arrangements.

   E. Give reassurance and positive support to the client to prepare him/her for the move.

   F. Allow the client time to respond to the situation.

   G. Introduce the client to the new area, staff, and roommate.

III. Discharge - the client goes to another facility, home, or to the home of a relative/friend.

IV. Nurse Assistant's Responsibilities in the Hospital Discharge of Client

   A. Charge nurse will inform the nurse assistant when client is to be discharged. Be sure client is clean and wearing appropriate clothing.

B. Relatives or ambulance will transport the client in most cases.

C. Make sure items are packed which the client would need during a hospital stay - gowns, pajamas, robe, dentures, personal care items, comb and brush. (CD-2).

D. If the room is to be held for client's return from hospital, put remaining belongings in personal storage area.

E. Be sure information about the client goes to the receiving facility with the client.

V. Nurse Assistant's Responsibilities in the Discharge of a Client to the Home or Another Long-Term Care Facility

A. A relative or friend usually comes for the client.

B. Make sure all belongings are sent with the client, check valuables and clothing lists.

C. Sometimes a client's clothing is sent home when he/she is admitted, and you must ask the family to bring clothing to dress the client for discharge.

D. Make sure the client's clothing is suitable for the weather.

E. If the client has special diet restrictions or medications are to be sent, check with the charge nurse before the client leaves the facility. The charge nurse is responsible for giving these to the client.

F. Check inside the bedside table drawers, closet and storage room to make sure nothing is forgotten.

G. The facility is responsible for the safety of the client until he/she is placed inside the car. (CD-3)

H. Strip the unit after the client has been discharged.

I. Check linen for possessions as you strip the bed.

J. Notify housekeeping so the unit can be thoroughly cleaned.

K. Remove, clean, and disinfect any utensils that are not disposable.

L. After the unit is cleaned, set it up so that it will be ready for the next admission.

LESSON PLAN: 61

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-61 OR DEMONSTRATION:

TEMPERATURE, PULSE, AND RESPIRATIONS (TPR)
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify the normal range of body temperature.
3. Identify three types of thermometers.
4. Recognize three ways to measure a temperature.
5. List three conditions that would indicate not to measure temperature by the oral route.
6. Describe the length of time to measure a temperature for each of the three routes.
7. Identify the normal pulse range.
8. List four locations at which a pulse can be checked.
9. Identify the normal range for respirations.
10. Recognize three signs of normal respirations.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Common Thermometers
2. HO 2: Sites for Measuring a Pulse
3. AS 1: Reading a Thermometer
4. Trainex filmstrip #371: "Temperature, Pulse, and Respirations"
5. TLC filmstrip: "How to Take Your Patient's Temperature"
6. TLC filmstrip: "How to Take Your Patient's Pulse and Respirations"
7. Projector

TEACHER RESOURCES:

INTRODUCTION:

Measuring temperature, pulse, and respirations is part of checking vital signs. This is a procedure that you must completely understand how to perform so that you will feel confident and be accurate. Some medications and treatments may be administered or discontinued depending upon what the vital signs are. If you are ever in doubt, ask the charge nurse to recheck your reading. The following lesson plan will give you some of the answers as to why these are considered the signs of life. The following lesson plans will then inform you of the actual steps of the procedure.

3. Each short mark is two-tenths of a degree; they go from 2/10 to 8/10 between the larger numbers

4. Two-tenths means the same whether it is written as 2/10 or .2 .

5. The small arrow (↑) indicates the normal oral temperature of 98.6°F (CD-4)

D. Locating the mercury

1. Hold the thermometer at the stem end; NEVER AT THE BULB END.

2. Stand with your back to the light.

3. Hold thermometer at eye level and rotate it slightly back and forth until the column of mercury is visible.

IV. Ways to Measure a Temperature

A. Oral

1. Most common and convenient way of measuring the temperature

2. Time required for an accurate reading is five to eight minutes

3. Average normal oral temperature is 98.6°F.

4. DO NOT MEASURE AN ORAL TEMPERATURE IF THE CLIENT:

    a. Has been smoking, chewing gum, or consumed a hot/cold beverage; wait 15 minutes (CD-5)

    b. Is unconscious

    c. Has had surgery or an injury to the face, neck, nose or mouth

    d. Is receiving oxygen

    e. Breathes through the mouth instead of the nose

    f. Is delirious, restless, confused or disoriented

    g. Is paralyzed on one side of the body due to a stroke

5. Instruct client not to talk during procedure.

LESSON PLAN: 61

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION

1. What is normal oral temperature considered to be?
2. What is the substance contained in a glass thermometer?
3. Are the probe covers used with an electronic thermometer reusable?
4. What does the small arrow indicate on a glass thermometer?
5. How long should you wait if a client has been chewing gum before checking the thermometer?
6. What should you remember to do before inserting a thermometer into the rectum?
7. When recording a rectal or axillary temperature, what should you do?
8. When checking an apical pulse, what piece of equipment do you need?
9. Is it normal for someone to breathe rapidly while resting?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students different types of thermometers.
2. Have students locate pulse at different sites.
3. Have students complete AS 1: Reading a thermometer.

LESSON PLAN: 60

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

1. Which one of the following is the purpose of transferring a client to another facility? (Circle the letter of the correct answer.)

   a. To introduce the client to more people his/her own age.
   b. To better provide for a client's care due to a change in the client's condition, due to incompatability with a roommate, or client's request for accommodation change.
   c. To prevent the client from staying in one room too long and becoming attached to the room.
   d. To improve the family relationship.

2. Define the word discharge as used in this lesson.

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 3. The long-term care client must be notified in advance of a transfer.

____ 4. A client should take all of his/her belongings when discharged to another hospital.

____ 5. The client is responsible for obtaining his/her own medications and diet instructions when discharged.

____ 6. As soon as the doctor writes the dismissal order, the long-term care facility is no longer responsible for the client.

____ 7. Information about the client should be sent along with him/her to the hospital.

____ 8. You should remove, clean, and disinfect any utensils that are not disposable after the client is discharged..

LESSON PLAN: 60

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. b
2. Discharge - the client goes to another facility, home, or to the home of a relative/friend.
3. T
4. T
5. F
6. F
7. T
8. T

LESSON PLAN: 61

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Terms and Definitions

- A. Axilla - armpit
- B. Body temperature - the amount of heat in the body that is a balance between the amount of heat produced and the amount lost by the body
- C. Cheyne-Stokes - a pattern of breathing in which respirations gradually increase in rate and depth and then become shallow and slow; breathing may stop for 10 to 20 seconds
- D. Pulse - the beat of the heart felt at an artery as a wave of blood passes through the artery
- E. Pulse rate - the number of heartbeats or pulses felt in one minute
- F. Respirations - act of breathing in and out of the lungs (inhalation/exhalation)
- G. Vital signs (signs of life) - temperature, pulse, respirations and blood pressure

II. Body Temperature

- A. A balance between heat gained and heat lost.
- B. Our body must have a constant temperature in order to function properly. (CD-1)
  - 1. Normal range for a resting person is 97oF to 99oF..
  - 2. Normal oral temperature is 98.6oF..
  - 3. Report to the charge nurse if temperature does not fall within this range.

C. Heat is conserved by the body as follows:

   1. Reduction of perspiration

   2. Vasoconstriction - decrease in flow of blood to skin.

   3. Shivering - increased muscle activity to produce heat

D. Heat is lost by the body as follows:

   1. Vasodilation - increased blood flow to skin, flushed appearance

   2. Through the lungs by breathing - increased respirations rate

   3. Elimination of urine, stool, and perspiration

E. Fever - an elevation of the body temperature above the usual normal range.

F. Measures to raise body temperature.

   1. Increase the temperature of the room.

   2. Add coverings to the body.

   3. Provide hot liquids to drink.

   4. Give warm bath or soaks.

G. Measures to lower body temperature

   1. Decrease the temperature of the room.

   2. Remove coverings from the body.

   3. Offer cool liquids to drink.

   4. Provide cool bath or sponging.

   5. Direct fan toward the body.

III. Measuring Body Temperature

A. Glass thermometer (CD-2)

   1. The thermometer has a bulb end and a stem end.

    2. Mercury collects in the bulb end; when warmed it rises up a hollow tube in the stem of the thermometer.

    3. The temperature is recorded at the point the mercury stops.

B. Types of thermometers: (HO-1)

    1. Glass with long, narrow tip

        a. Used for oral or axillary temperatures

        b. Color-coded blue

        c. Never used to measure rectal temperature because it could injure tissues in the rectum

    2. Glass with rounded, stubby tip

        a. Used for measuring rectal temperature

        b. Color-coded red

    3. Electronic

        a. Portable and battery operated

        b. Measures temperature within 2 to 60 seconds, depending upon model.

        c. Displays temperature digitally on front of thermometer unit.

        d. Oral (blue) and rectal (red) probes are supplied.

        e. Disposable cover or sheath is used to cover the probe.

        f. Use the covers only once and then discard. (CD-3)

C. Reading a glass Fahrenheit scale thermometer

    1. Each long line represents one degree - 94^0, 95^0, etc.

    2. Odd-numbered degrees (95^0, 97^0, etc.) are not written on the thermometer

B. Rectal

1. Most accurate measure of body temperature; but this route is not routinely used except when oral measurement cannot be used for reason(s) listed previously.

2. Time required for an accurate reading is three to four minutes.

3. Average normal rectal temperature is 99.6°F.

4. Client should not be left alone during procedure; thermometer should always be held while temperature is being measured with client on his/her side.

5. Lubrication of thermometer is important so that it can be inserted easily and not cause tissue injury.

6. DO NOT MEASURE A RECTAL TEMPERATURE IF THE CLIENT:

   a. Has diarrhea

   b. Has a rectal disorder, injury or recent rectal surgery (CD-7)

7. In charting, indicate rectal method by writing "R" after the numbers; for example 99 R.

C. Axillary

1. Least accurate method; used only when temperature cannot be measured orally or rectally.

2. Time required for an accurate reading is 10 to 12 minutes.

3. Average normal axillary temperature is 97.6° F.

4. This method should not be used immediately after bathing; the axilla should be dry. Thermometer should be held in place to maintain proper position.

5. In charting, indicate axillary method by writing "A" after the numbers; for example 96.8°A.

V. Pulse

A. Pulse is the beat of the heart felt at an artery as a wave of blood passes through the artery; a pulse can be felt every time the heart beats.

B. Pulse rate is the number of beats felt in 1 minute; The normal range for an adult is between 60 to 100 beats per minute. Report to charge nurse if pulse does not fall within this range.

1. Normal range for an infant is 100-140 beats per minute.
2. Normal range for a child is 80-110 beats per minute.

C. Factors that elevate the pulse

1. Exercise

2. Strong emotions (anger, fear, etc.)

3. Fever

4. Pain

5. Shock

D. Factors that lower the pulse

1. Resting

2. Depression

3. Certain drugs (such as digitalis)

VI. Measuring the Pulse

A. When measuring the pulse, count the rate for one full minute.

B. When measuring the pulse note the rhythm of the pulse.

1. Regular rhythm - pulse is felt in a pattern with the same time interval occurring between beats.

2. Irregular rhythm - noted when the beats are unevenly spaced or beats are skipped.

C. When measuring the pulse, note the force of the pulse.

1. A forceful pulse is easy to feel and is described as being strong, full, or bounding.

2. A weak pulse is hard to feel and is described as weak or thready.

VII. Sites for Measuring Pulse (HO 2)

A. Radial pulse

1. Most common and convenient site.

2. Pulse is located on the side of the wrist near the client's thumb; it can be felt by placing the first three fingers of one hand against the radial artery.

3. Do not measure the pulse with your thumb, it has a pulse of its own, which could be mistaken for the client's pulse.

4. It is routine to measure a client's pulse and respirations while measuring the temperature.

5. Do not record the pulse immediately; keep the number in mind and continue holding the client's hand until you have counted the respirations.

B. Carotid pulse (used in CPR mainly - not good for vital signs)

1. Located on the side of the neck.

2. Check one side at a time; never push on both carotid arteries at the same time--this will cause fainting.

C. Brachial pulse - located at the bend of the elbow

D. Femoral pulse - located at the groin area

E. Apical pulse

1. Located on the left side of the chest slightly below the nipple; must use a stethoscope to listen to pulse beat.

2. The heartbeat normally sounds like a "lub-dub." Each "lub-dub" is counted as one beat.

VIII. Respirations

A. One respiration includes breathing in and breathing out; the chest rises upon inhalation and falls during exhalation.

B. Respiratory rate is the number of respirations in one minute; the normal range for an adult is between 14 and 20. Report to the charge nurse if respirations do not fall within this range.

   1. Normal range for an infant is more rapid.
   2. Normal range for the elderly is more slow.

C. The respiratory rate is affected by the same factors as those that can elevate/lower the pulse.

IX. Measuring Respirations (CD-9)

A. Normal respirations are:

   1. Quiet

   2. Effortless

   3. Regular

   4. Both sides of chest rise and fall equally

B. To count respirations you must be able to see the chest rise and fall. The client must not be aware that you are counting respirations because he/she may subconsciously or intentionally alter the pattern.

C. Count the respirations right after counting the pulse; the fingers should be left in place over the pulse site, thus the client will assume that the pulse is still being counted.

X. Summary and Conclusion

A. Body temperature

B. Measuring body temperature

C. Ways to measure a temperature

D. Pulse

E. Measuring the pulse

F. Sites for measuring a pulse

G. Respirations

H. Measuring respirations

Measuring the TPR contributes to the overall evaluation of the client's condition. It should be done with great accuracy and whenever there is an indication of change of condition. Most facilities check the client's TPR at least once a month.

LESSON PLAN: 61

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT________________

Match the following terms to correct definitions by writing the letter in the blank.

_____	1. Axilla	a. Act of breathing in and out of the lungs
_____	2. Body temperature	b. Balance of amount of heat produced and amount of heat lost by the body
_____	3. Cheyne-Stokes	c. TPR and BP
_____	4. Pulse	d. A pattern of breathing in which respirations are uneven and may stop for brief periods
_____	5. Pulse rate	e. Armpit
_____	6. Respirations	f. The beat of the heart felt at an artery as a wave of blood passes through it
_____	7. Vital signs	g. The number of heartbeats felt in one minute

8. Write down the normal adult ranges for temperature, pulse, and respirations:
   a. Temperature -
   b. Pulse -
   c. Respirations -

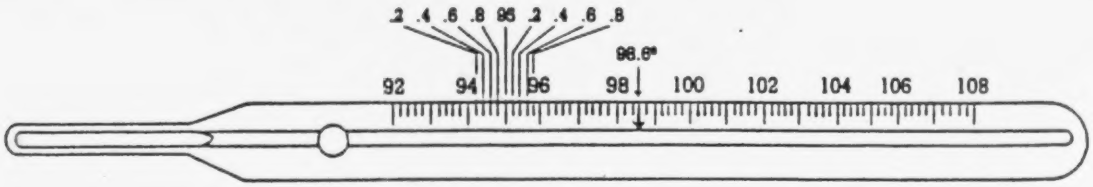
9. Which of the following is not a type of thermometer used? (Circle the letter of the correct answer.)
   a. Electronic
   b. Glass with long, narrow tip
   c. Stethoscope
   d. Glass with rounded, stubby tip

COMMON THERMOMETERS

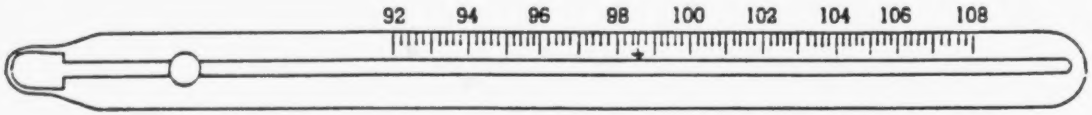
HO 1

COMMON THERMOMETERS

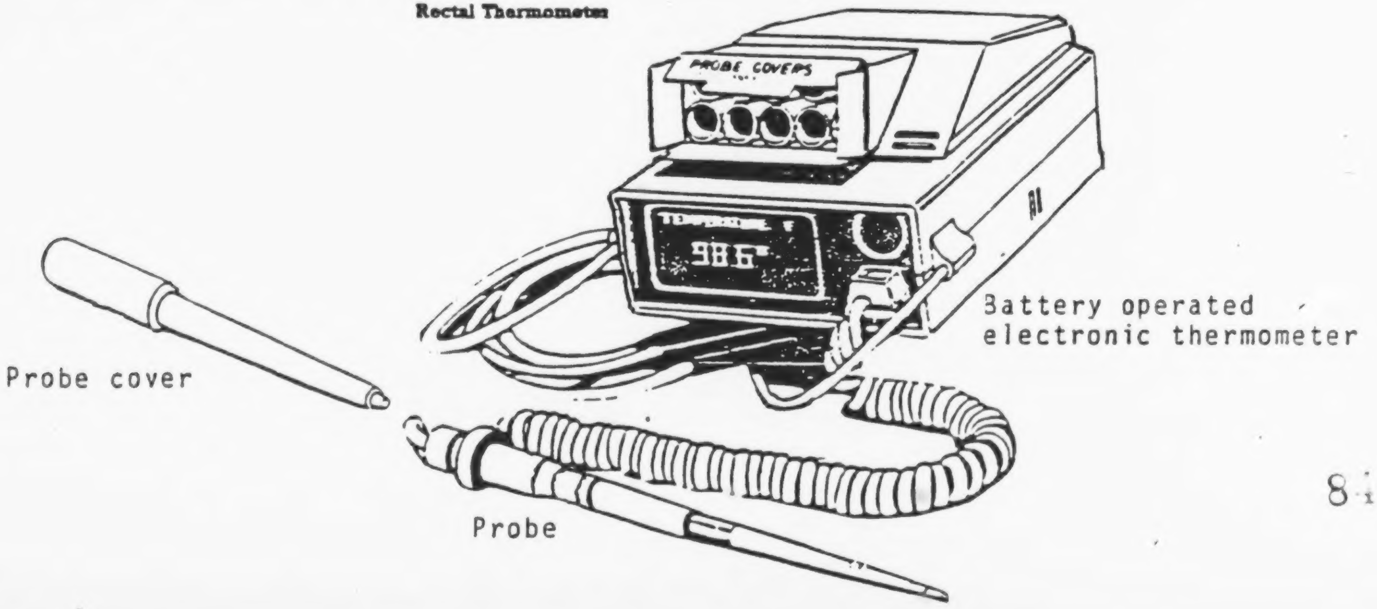
(Fahrenheit)


.2 .4 .6 .8 95 .2 .4 .6 .8
98.6°
92
94
96
98
100
102
104
106
108

Oral Thermometer


92
94
96
98
100
102
104
106
108

Rectal Thermometer


PROBE COVERS
98.6°
Probe cover
Probe
Battery operated
electronic thermometer

10. Which of the following is not a way to measure a temperature?

    a. Under the knee
    b. Axilla
    c. Rectal
    d. Oral

11. List three conditions that would indicate not to measure a temperature by the oral route.

    a.

    b.

    c.

12. Describe the three routes to be used and how long you should measure the temperature by each route.

    a.

    b.

    c.

13. List five locations at which a pulse can be checked.

    a.

    b.

    c.

    d.

    e.

14. Which of the following are signs of normal respirations? (Circle the correct answer)

    a. Effortless
    b. Regular
    c. Quiet
    d. All of the above

LESSON PLAN: 61

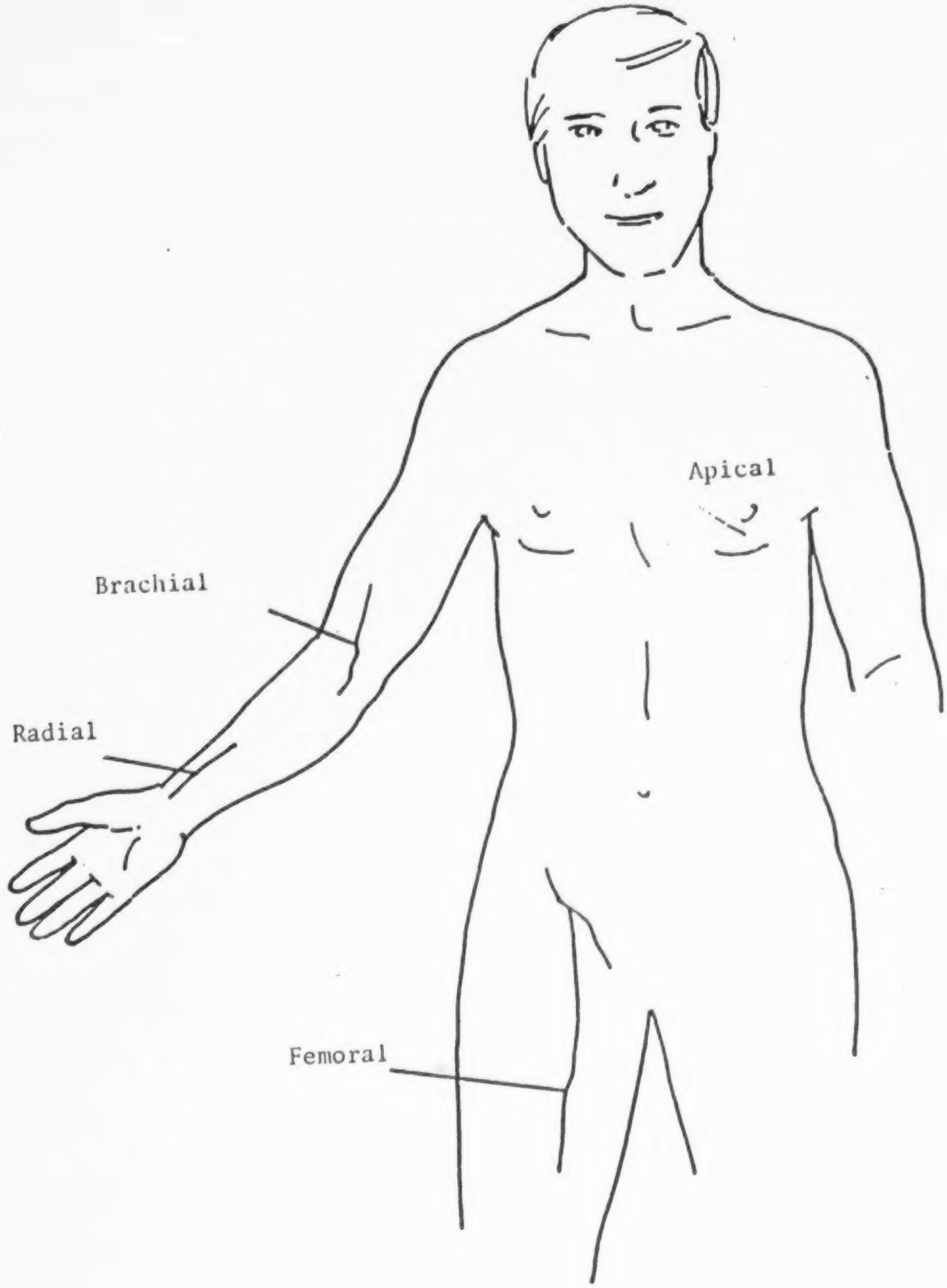
COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. e
2. b
3. d
4. f
5. g
6. a
7. c
8. a. Temperature - 97oF-99oF
   b. Pulse-for an adult - 60-100 beats/minute
   c. Respirations-for an adult - 14-20/minute
9. c
10. a
11. The student may list any three of the following:
    a. If client is unconscious.
    b. If client has had surgery or an injury to the face, neck, nose, or mouth.
    c. If client is receiving oxygen.
    d. If client breathes through the mouth instead of the nose.
    e. If client is delirious, restless, confused or disoriented.
    f. If client is paralyzed on one side of the body due to a stroke.
    g. If client has been smoking, chewing gum, or just consumed a hot/cold beverage. Wait 15 minutes.
12. a. Oral - most convenient and common way of measuring the temperature; time required is five to eight minutes.
    b. Rectal - most accurate method; generally used when oral temperature cannot be measured; time required is three to four minutes
    c. Axillary - lease accurate method; used when oral or rectal temperature cannot be measured; time required is 10-12 minutes
13. a. Radial - side of wrist near client's thumb
    b. Carotid - side of neck
    c. Brachial - bend of elbow
    d. Femoral - groin area
    e. Apical - left side of chest slightly below nipple
14. d

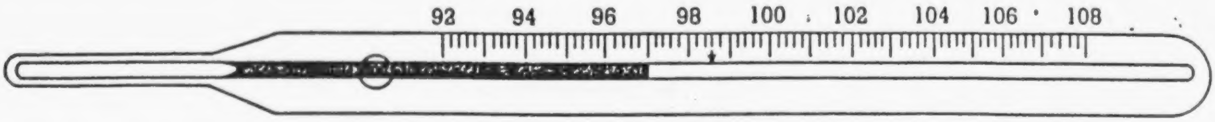
SITES FOR MEASURING A PULSE


Apical
Brachial
Radial
Femoral

READING A THERMOMETER

1. Write the readings on these thermometers in the blanks to the right.

a. ______________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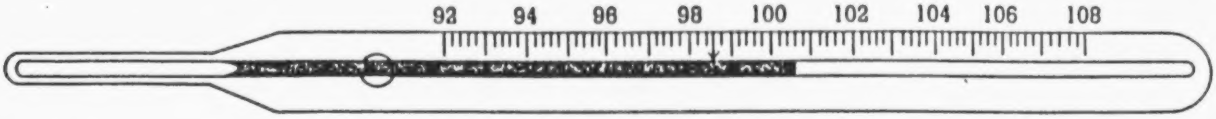
b. ______________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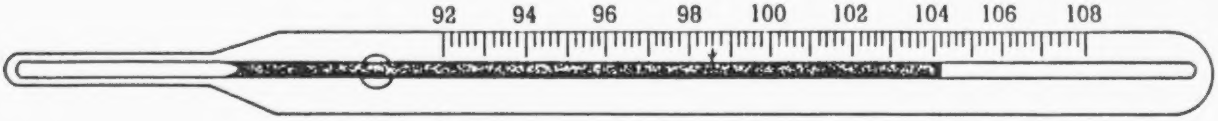
c. ______________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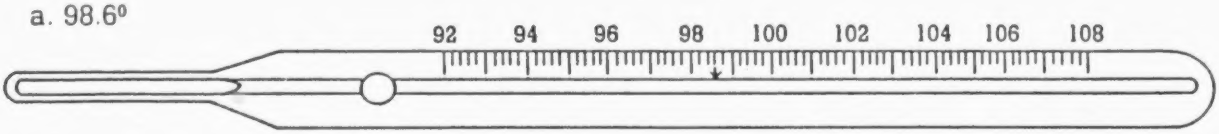
2. Mark the temperature readings on these thermometers.

a. 98.6°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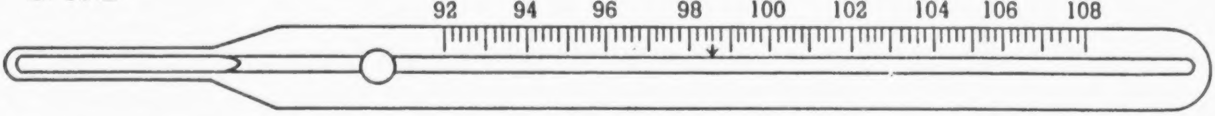
b. 99.2°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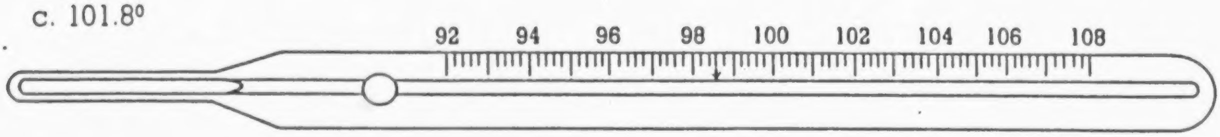
108

c. 101.8°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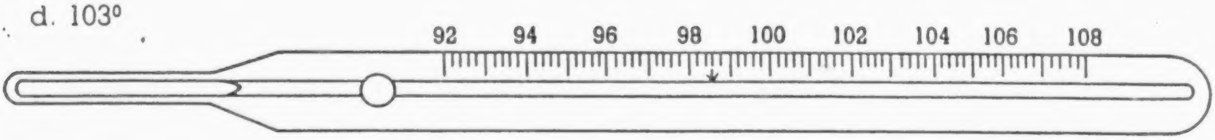
d. 103°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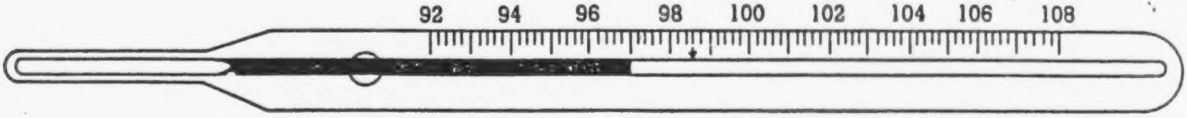
ANSWERS TO ASSIGNMENT SHEET-1
READING A THERMOMETER

1. Write the readings on these thermometers in the blanks to the right.

a. 97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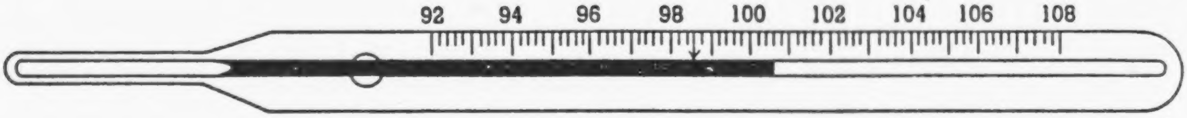
b. 100.6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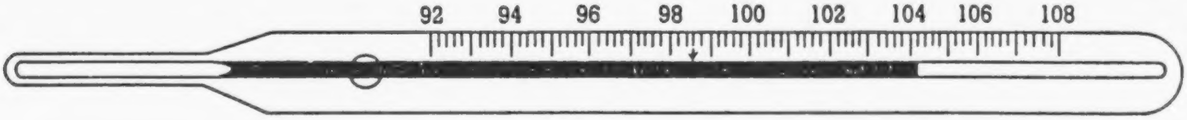
c. 104.2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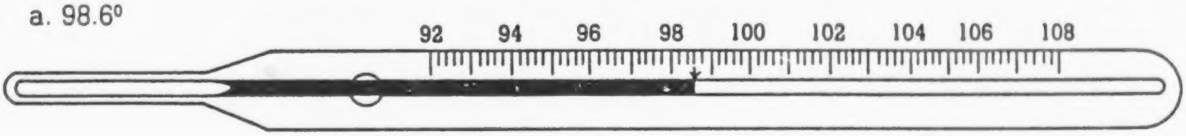
2. Mark the temperature readings on these thermometers.

a. 98.6°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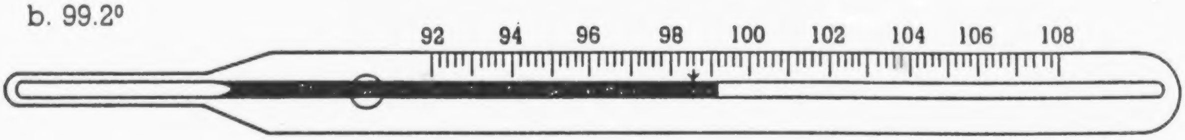
b. 99.2°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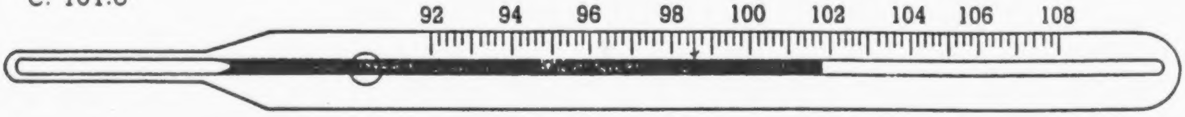
c. 101.8°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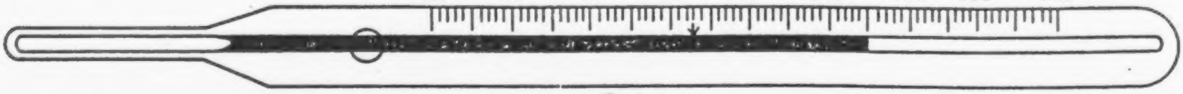
d. 103°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LESSON PLAN: 62

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-62

MEASURING and RECORDING A TPR
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to measure an oral temperature according to the steps of procedure.
2. Demonstrate how to measure a rectal temperature according to the steps of procedure.
3. Demonstrate how to measure an axillary temperature according to the steps of procedure.
4. Demonstrate how to count pulse and respirations according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Glass oral thermometer and holder
2. Glass rectal thermometer and holder
3. Electronic thermometer with oral and rectal probes and disposable probe covers.
4. Tissues
5. Plastic thermometer cover (if available)
6. Paper and pen
7. Water-soluble lubricant (rectal)
8. Disposable gloves (rectal), if available
9. Towel (axillary)
10. Chase doll

TEACHER RESOURCES:

INTRODUCTION:

Now that you, the nurse assistant, have an understanding of the importance of TPR, the actual steps to be taken when performing this procedure will be presented. The procedures will demonstrate how to measure a temperature by three different routes as well as using the various types of thermometers.

LESSON PLAN: 62

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE:

Measuring Oral Temperature, Pulse, and Respirations:

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.
6. Rinse thermometer with cool water if it has been soaked in disinfectant solution.
7. Check thermometer for breaks or chips.
8. Shake down thermometer to 95oF or below: firmly grasp at the stem end and snap your wrist several times. (CD-2)

TPR procedure

9. Client should be sitting or lying down. (CD-1)
10. Ask client to open mouth and raise tongue. Place the thermometer bulb under the client's tongue in the middle of the mouth.
11. Instruct the client to hold the thermometer in place by closing his/her lips around the thermometer, while holding bulb under tongue. Leave in place for at least five minutes.
12. Rest client's arm across his/her chest for ease in observing rise and fall or chest cavity during respirations.
13. Place finger tips over radial artery and locate pulse. (CD-3)
14. Note if the pulse is strong or weak and regular or irregular. (CD-4)

15. Count the pulse for one full minute.

16. Continue to hold the client's wrist and begin counting when you see the chest rise; count respirations for one full minute.

17. Note any abnormal characteristics of either pulse or respirations.

18. Recount either pulse or respirations if unsure.

19. Record pulse and respirations on paper.

20. Grasp the stem end of the thermometer and remove it from the client's mouth and wipe it from the stem toward the bulb end with a tissue (clean to dirty. (CD-5)

21. Read the thermometer.

22. Record the temperature on the paper.

23. Shake down the thermometer.

Steps ending procedure

24. Remove, clean, and store equipment.

25. Wash your hands.

26. Make the client comfortable; place call signal within reach.

27. Record observations.

NOTE: Report anything unusual to the charge nurse.

Measuring Oral Temperature with an Electronic Thermometer

Steps beginning procedure

1-5. See steps 1-5 of taking oral temperature, pulse, and respirations procedure.

Oral temperature procedure

6. Client should be sitting or lying down.

7. Make sure oral probe is plugged into the thermometer.

8. Remove the probe from the unit and insert it into a probe cover.

9. Ask client to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.

10. Ask the client to lower the tongue and close the mouth. Hold the probe in the client's mouth.

11. Read the temperature on the digital display when the tone is heard or when there is a flashing or steady light. (CD-6)

12. Remove the covered probe from the client's mouth and discard the probe cover by pressing the eject button.

13. Record the temperature on paper.

14. Return the probe to the holder.

15-22. Count pulse and respirations. See steps 12-19 of taking oral temperature, pulse, and respirations procedure. (CD-7)

Steps ending procedure

23-26 See steps 24-27 of taking oral temperature, pulse, and respirations procedure.

Measuring Rectal Temperature

Steps beginning procedure

1-8. See steps 1-8 of taking oral temperature, pulse, and respirations procedure.

Measure rectal temperature

9. Client should be lying on his/her side with upper leg flexed. (CD-8)

10. Wear disposable gloves.

11. Rinse thermometer with cool water if it has been soaked in disinfectant solution.

12. Check thermometer for breaks or chips.

13. Shake down thermometer to 95^{0} F or below; firmly grasp at the stem end and snap your wrist several times.

14. Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer.

15. Raise the upper buttock to expose the anus; insert bulb end of the thermometer one inch into the rectum. (CD-9)

16. Hold the thermometer in place for three to four minutes.

17. Remove the thermometer. Wipe it clean with tissues from the stem toward the bulb.

18. Place the thermometer on clean toilet tissue, wipe the anal area to remove excess lubricant.

19. Cover the client.

20. Read the thermometer and record temperature on paper.

21. Shake down the thermometer.

Steps ending procedure

22-25. See steps 24-27 of taking oral temperature, pulse, and respirations procedure.

26-33. Pulse and respirations may be measured as in oral temperature procedure after the temperature measured; see I.B., steps 12-19 of measuring oral temperature, pulse, and respirations procedure. (CD-10)

Measuring an Axillary Temperature

Steps beginning procedure

1-8 See steps 1-8 of taking oral temperature, pulse, and respirations procedure.

Measuring an axillary temperature

9. Client should be sitting or lying down. (CD-11)

10. Help the client remove an arm from the sleeve of the gown.

NOTE: Do not expose the client.

11. Dry axilla of excessive perspiration with a towel.

12. Place bulb end of thermometer in the center of axilla.

13. Bring the arm across the chest to snugly hold the thermometer in place for 10 to 12 minutes.

14-21. Pulse and respirations may be measured while thermometer is in place. See steps 12-19 of measuring oral temperature, pulse, and respirations procedure.

22. Remove thermometer and read it.

23. Shake down the thermometer.

Steps ending procedure

24-27. See steps 24-27 of measuring oral temperature, pulse, and respirations procedure.

SUMMARY AND CONCLUSION:

1. Classroom discussion.
2. Review steps of procedures.

	YES	NO
8. Shake down thermometer to 95°F or below		
B. TPR procedure 9. Position client in sitting or lying down position.		
10. Ask client to open mouth and raise the tongue. Place the thermometer bulb under the client's tongue in the middle of the mouth.		
11. Instruct the client to hold the thermometer in place by closing his/her lips around the thermometer. Leave in place for at least five minutes.		
12. Rest client's arm across his/her chest for ease in observing rise and fall of chest cavity during respirations.		
13. Place finger tips over radial artery and locate pulse.		
14. Note if the pulse is strong or weak and regular or irregular.		
15. Count the pulse for one full minute.		
16. Continue to hold the client's wrist and count respirations for one full minute.		
17. Note any abnormal characteristics of either pulse or respirations.		
18. Recount either pulse or respirations in unsure.		
19. Record pulse and respirations on paper.		

	YES	NO
20. Grasp the stem end of the thermometer and remove it from the client's mouth and wipe it from the stem toward the bulb end with a tissue (clean to dirty).		
21. Read the thermometer.		
22. Record the temperature on the paper.		
23. Shake down the thermometer.		
C. Steps ending procedure 24. Remove, clean, and store equipment.		
25. Wash hands.		
26. Make the client comfortable; place call signal within reach.		
27. Record observations and report anything unusual to the charge nurse		
Measuring an Oral Temperature with an Electronic Thermometer A. Steps beginning procedure 1-5. Complete steps 1-5 of measuring oral temperature, pulse, and respirations procedure.		
B. Oral temperature procedure 6. Position client in sitting/lying down position.		
7. Make sure oral probe is plugged into the thermometer.		

LESSON PLAN: 63

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-63 OR DEMONSTRATION:

BLOOD PRESSURE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match terms presented in this lesson to correct definitions.
2. Identify the normal range for systolic blood pressure.
3. Identify the normal range for diastolic blood pressure.
4. Recognize equipment used to measure a blood pressure.
5. Identify key points in measuring blood pressure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. AS 1: Reading a Mercury Sphygmomanometer
2. AS 2: Reading an Aneroid Sphygmomanometer
3. Trainex filmstrip #367: "Blood Pressure"
4. TLC filmstrip #3: "How to Take your Patient's Blood Pressure - Part II"
5. TLC filmstrip #4: "How to Take Your Patient's Blood Pressure - Part II"
6. Projector
7. Sphygmomanometer with blood pressure cuff

C. Stethoscope

1. An instrument that amplifies sound (CD-7)
2. Position the stethoscope for use with the earpieces facing forward.
3. Use the flat diaphragm side of the stethoscope.
4. Do not put too much pressure on the diaphragm of the stethoscope because this will maintain pressure on the artery.
5. Always clean the earpieces with alcohol before and after the blood pressure is measured.

IV. Measuring the Blood Pressure

A. Blood pressure should never be measured on an arm with an IV infusion or a cast.

B. Normally measured in the brachial artery of one of the arms.

C. Room should be quiet so that the BP can be heard; talking, noises from T.V. and radio should be stopped.

D. The manometer must be clearly visible.

E. Arm should be supported at heart level.

F. Systolic reading is the first sound you hear as you let the air out; blood begins to flow through the artery with force as the heart contracts. (CD-8)

G. Diastolic reading is the last sound you hear as you let the air out or the point that it changes to a soft, muffled thump; blood flows freely through the artery when the heart relaxes. (CD-9)

H. If the sounds become muffled before stopping or remains muffled down to zero, record the diastolic at the point when you hear the change from clear to muffled, and when the sound ends. For example: 136/74/42

V. Summary and Conclusion

A. Terms and definitions
B. Blood pressure measurement
C. Equipment used to measure a blood pressure reading
D. Measuring the blood pressure

LESSON PLAN: 62

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. What position should the client be in when measuring an oral temperature?

2. To what degree should the thermometer be shaken down?

3. Where are the fingers placed when measuring the pulse?

4. What should you note about the pulse when counting it?

5. In what direction is the thermometer wiped before being read?

6. How do you know when the temperature is to be read when using an electronic thermometer?

7. When would you count the pulse and respirations when measuring temperature using an electronic thermometer?

8. What position should the client be in when measuring a rectal temperature?

9. How far should the thermometer be inserted into the rectum?

10. When should you count the pulse and respirations when measuring a rectal temperature?

12. What position should the client be in when measuring an axillary temperature?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates temperature, pulse, and respiration procedure.

2. Students practice measuring each others temperature, pulse, and respirations.

3. Students practice inserting a rectal thermometer using Chase doll.

LESSON PLAN: 62

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT ____________________

MEASURING A T.P.R.

EQUIPMENT:

1. Glass oral thermometer and holder
2. Glass rectal thermometer and holder
3. Electronic thermometer with oral and rectal probes and disposable probe covers
4. Tissues
5. Plastic thermometer cover (if available)
6. Paper and pen
7. Water-soluble lubricant (rectal)
8. Disposable gloves (rectal), if available
9. Towel (axillary)
10. Chase doll

DID THE STUDENT	YES	NO
Measuring Oral Temperature, Pulse, and Respirations		
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
6. Rinse thermometer with cool water if it has been soaked in disinfectant solution.		
7. Check thermometer for breaks or chips.		

	YES	NO
8. Remove the probe from the unit and insert it into a probe cover.		
9. Ask client to open the mouth and raise the tongue; place covered probe at the base of the tongue on either side.		
10. Ask the client to lower the tongue and close the mouth. Hold the probe in the client's mouth.		
11. Read the temperature on the digital display when the tone is heard or when there is a flashing or steady light.		
12. Remove the covered probe from the client's mouth and discard the probe cover by pressing the eject button.		
13. Record the temperature on paper.		
14. Return the probe to the holder.		
15-22. Count pulse and respirations. Complete steps 12-19 or oral temperature, pulse, and respirations procedure.		
C. Steps ending procedure 23-26. Complete steps 24-27 of taking oral temperature, pulse, and respirations procedure.		
Measuring Rectal Temperature A. Steps beginning procedure 1-8. Complete steps 1-8 of taking oral temperature, pulse, and respirations procedure.		

	YES	NO
B. Measure a rectal temperature		
9. Instruct/assist client to lie on his/her side with upper leg flexed.		
10. Wear disposable gloves.		
11. Rinse thermometer with cool water if it has been soaked in disinfectant solution		
12. Check thermometer for breaks or chips.		
13. Shake down thermometer to 95oF or below.		
14. Put a small amount of lubricant on a tissue and lubricate the bulb end of the thermometer.		
15. Raise the upper buttock to expose the anus; insert bulb end of thermometer one inch into the rectum.		
16. Hold the thermometer in place for three to four minutes.		
17. Remove the thermometer. Wipe it clean with tissue, from stem to bulb.		
18. Place the thermometer on clean toilet tissue, wipe the anal area to remove excess lubricant.		
19. Cover the client.		
20. Read the thermometer and record temperature on paper.		
21. Shake down the thermometer.		

	YES	NO
C Steps ending procedure 22-25. Complete steps 24-27 of measuring oral temperature, pulse, and respirations procedure. 26-33. Count pulse and respirations. Complete steps 12-19 of measuring oral temperature, pulse, and respirations procedure.		
A. Steps beginning procedure 1-8. Complete steps 1-8 of measuring oral temperature, pulse, and respirations procedure.		
B. Measuring an axillary temperature 9. Instruct/assist client to sit or lie down.		
10. Help the client remove an arm from the sleeve of the gown without exposing client.		
11. Dry axilla of excessive perspiration with a towel.		
12. Place bulb end of thermometer in the center of axilla.		
13. Bring the arm across the chest to snugly hold the thermometer in place for 10 to 12 minutes.		
14-21. Pulse and respirations may be measured while thermometer is in place. Complete steps 12-19 of measuring oral temperature, pulse, and respirations procedure.		
22. Remove thermometer and read it.		
23. Shake down the thermometer.		
24-27. Complete steps 24-27 of measuring oral temperature, pulse, and respirations procedure.		

The student has satisfactorily completed the procedure "MEASURING A TPR" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

TEACHER RESOURCES:

INTRODUCTION:

The last procedure in measuring the vital signs is measuring the blood pressure. This procedure requires an understanding of what you are actually listening to and familiarity with the equipment used. Certain factors can alter the reading, thus producing an inaccurate measurement. Treatment can be based on BP readings which, if not read correctly, could result in harm to the client.

LESSON PLAN: 63

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE : (Key Points)

I. Terms and Definitions

- A. Blood pressure - the amount of force exerted against the walls of an artery by the blood
- B. Diastolic pressure - the pressure in the arteries when the heart is at rest
- C. Hypertension - high blood pressure; persistent BP measurements above the normal systolic (150 mm Hg) or diastolic (90 mm Hg) pressures
- D. Hypotension - low blood pressure; condition in which systolic BP is below 100 mm Hg and diastolic pressure is below 60 mm Hg
- E. Sphygmomanometer - instrument used to measure BP that consists of a cuff which is applied to the upper arm and a measuring device
- F. Stethoscope - instrument used to listen to the sounds produced by the heart, lungs, and other body organs
- G. Systolic pressure - amount of force it takes to pump blood out of the heart into the arterial circulation

II. Blood Pressure Measurement

- A. Blood pressure measurement consists of measuring the systolic and diastolic pressures.
- B. Systole is the period of heart muscle contraction. Systolic pressure is the highest pressure and represents the amount of force it takes to pump blood out of the heart into the arteries. (CD-1)
- C. Diastole is the period of heart muscle relaxation. Diastolic pressure is the lowest pressure and represents the amount of pressure in the arteries when the heart is at rest. (CD-2)

D. Factors that can increase blood pressure measurement

   1. Strong emotions
   2. Pain
   3. Exercise
   4. Some disease conditions

E. Factors that can lower blood pressure measurement

   Resting

   Depression

   Hemorrhage

   Shock

F. Normal range of blood pressure

   1. Systolic - 100 to 150 mm Hg
   2. Diastolic - 60 to 90 mm Hg

   } Lower for children

G. Hypertension - persistent blood pressure measurements above normal systolic and diastolic pressures (CD-3)

H. Hypotension - persistent blood pressure measurements below normal systolic and diastolic pressures

III. Equipment Used to Measure a Blood Pressure Reading

A. Sphygmomanometer

   1. Two types

      a. Mercury manometer - has an upright gauge with a straight column of numbers

         1. The dial is marked off from zero to 300. (CD-4)
         2. It has measurements for each 10 points.

        3. Small lines between the large lines represent two point intervals.

        4. View it with your eye at the same level as the top of the mercury column.

    b. Aneroid manometer - has a round gauge with spring type arrow pointing to numbers

        1. The dial is marked off in unit measurements of 20 to 300; zero is at the center bottom of the gauge..

        2. Small lines between the large lines represent two point intervals.

        3. View it from straight on; do not view it from the side.

2. The mercury column and the needle on the aneroid manometer should be at the zero mark when not in use.

B. Cuff

1. A long narrow piece of fabric that is wrapped around the arm and secured with Velcro; has a rubber bag at one end that fills with air when bulb is pumped and applies pressure on the artery to stop the flow of blood.

2. Should be placed so that the center of the bag is over the brachial artery about one inch above the elbow. (CD-5)

3. Cuff should be applied to the bare upper arm; do not apply over clothing. Remove clothing that will be too tight when moved to upper arm. (CD-6)

4. Cuff should be wrapped snugly but not too tightly.

5. Tubing connects the cuff to the manometer and another tube connects the cuff to a small hand-held bulb; a valve on the bulb is turned to allow inflation of the cuff as the bulb is squeezed. By turning it in the opposite direction it allows deflation of the cuff and measurement of the blood pressure.

LESSON PLAN: 63

COURSE TITLE: NURSE ASSISTANT
UNIT IX : SPECIALPROCEDURES

CLASSROOM DISCUSSION

1. What happens to heart muscle during the systolic phase?
2. What happens to heart muscle during the diastolic phase?
3. What is the difference between hypertension and hypotension?
4. Each small line on the manometer indicates how many points?
5. Over what artery do you usually place the cuff?
6. Is it appropriate to measure a blood pressure with clothing covering the arm?
7. Which direction should the earpieces be facing when putting on a stethoscope?
8. At what point is the systolic reading noted?
9. At what point is the diastolic reading noted?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor shows students equipment used to measure a blood pressure reading.
2. Have students fill out assignment sheets for measuring blood pressure.
3. Show filmstrip.

LESSON PLAN: 64

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION

1. What position should the client be in when having his/her blood pressure measured?
2. Why should you clean the earpieces on the stethoscope?
3. How far up do you pump the cuff?
4. In what direction do you turn the valve to release air from the cuff?
5. What should you do if you hear pulse sounds immediately?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates the blood pressure procedure
2. Students practice measuring each other's blood pressure.

LESSON PLAN: 63

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

Match the following terms to correct definitions by writing the letter in the blank.

_____	1.	Blood pressure	a.	Amount of force necessary to pump blood out of the heart into the arterial circulation
_____	2.	Diastolic pressure	b.	High blood pressure
_____	3.	Hypertension	c.	Amount of force exerted against the walls of an artery by the blood
_____	4.	Hypotension	d.	Pressure in the arteries when the heart is at rest
_____	5.	Sphygmomanometer	e.	Low blood pressure
_____	6.	Stethoscope	f.	Used to measure BP; includes cuff and a measuring device
_____	7.	Systolic pressure	g.	Used to listen to the sounds produced by the heart, lungs and other body organs

8. What is the normal range for systolic pressure?

9. What is the normal range for diastolic pressure?

10. Which one of the following pieces of equipment is not needed to measure a blood pressure? (Circle the letter of the correct answer.)

    a. Sphygmomanometer
    b. Stethoscope
    c. Otoscope
    d. Cuff

For each of the following, write "T" if the statement is true, or "F", if it is false.

_____ 11. If the client has an IV infusing, do not measure the blood pressure in that arm.

_____ 12. It is not appropriate to turn the client's television off when measuring a blood pressure.

_____ 13. Systolic reading is the first sound you hear as you let the air out of the cuff.

_____ 14. Diastolic reading is the sound you hear when blood flows freely through the artery when the artery relaxes.

_____ 15. The arm should be placed above the heart to get an accurate reading.

LESSON PLAN: 63

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

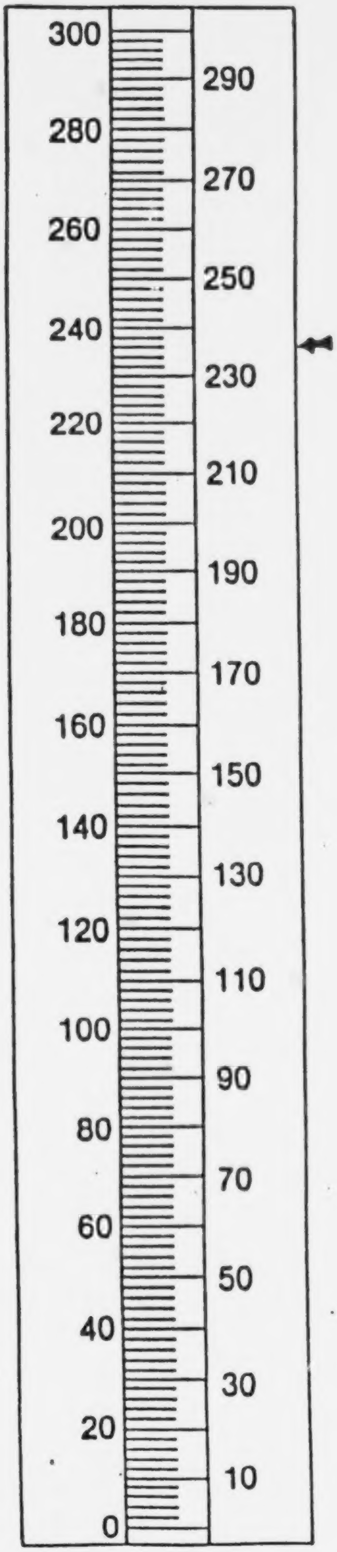
ANSWERS TO EVALUATION ITEMS:

1. c
2. d
3. b
4. e
5. f
6. g
7. a
8. Systolic pressure - normal range is 100 to 150 mm Hg
9. Diastolic pressure - normal range is 60 to 90 mm Hg
10. c
11. T
12. F
13. T
14. T
15. F

READING A MERCURY SPHYGMOMANOMETER

AS 1

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line out from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.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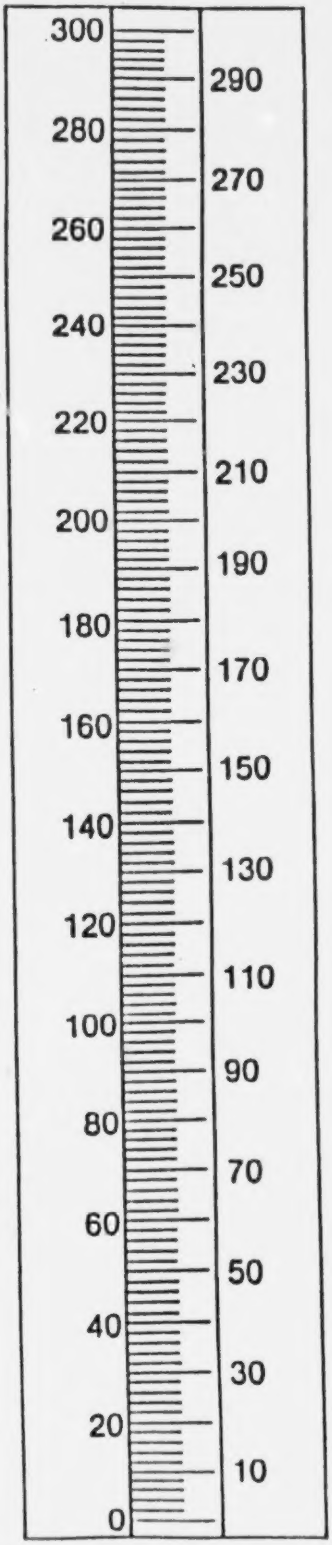
BP 158/112

BP 92/48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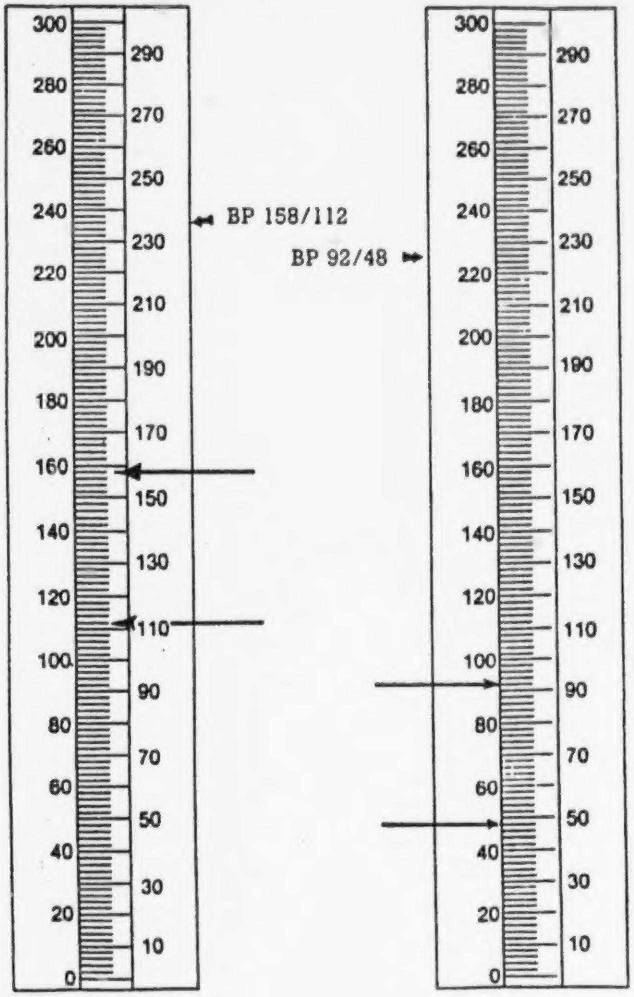
ANSWERS TO ASSIGNMENT SHEETS

AS 1

READING A MERCURY SPHYGMOMANOMETER

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line out from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.



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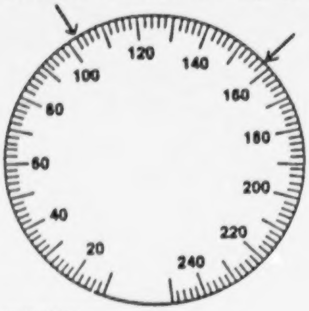
BP 158/112
BP 92/48

ANSWERS TO ASSIGNMENT SHEETS

AS 2

READING AN ANEROID SPHYGMOMANOMETER

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line out from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.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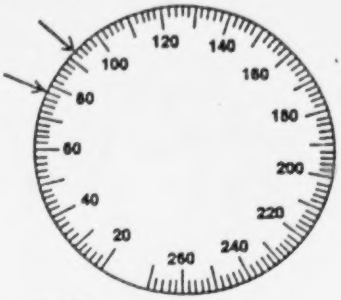
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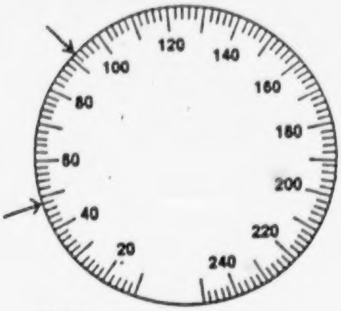
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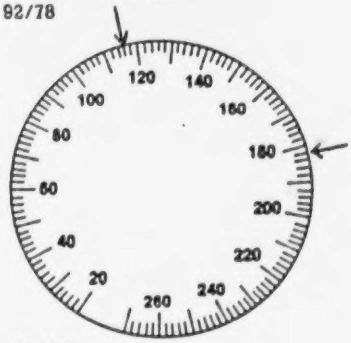
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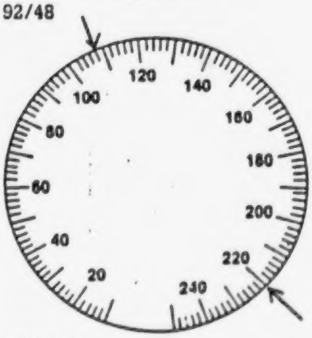
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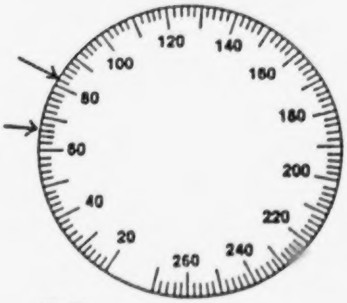
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LESSON PLAN: 64

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; and preventing and caring for decubitus ulcers; and caring for client's receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-64

MEASURING AND READING A BLOOD PRESSURE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to measure a blood pressure according to the steps of the procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Sphygmomanometer
2. Stethoscope
3. Alcohol sponges
4. Note pad and pencil

TEACHER RESOURCES:

INTRODUCTION:

The following procedure will demonstrate how to correctly measure and read a blood pressure. It is important to remember that you must practice this procedure many times before you will feel proficient. It is necessary to concentrate on what you are doing and to take your time.

LESSON PLAN: 64

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE:

Measuring and Reading a Blood Pressure

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

Blood pressure procedure

6. Position client seated or lying down with the entire lower arm on a flat surface, palm upward. (CD-1)
7. Expose the arm as much as possible. Squeeze the cuff to expel any remaining air and turn the valve clockwise on the bulb to close it, using right hand thumb and forefinger.

   NOTE: Do not turn it too tightly or you will have trouble opening it.
8. Wrap cuff snugly around the upper arm.
9. Clean earpieces of stethoscope with alcohol sponge. (CD-2)
10. Locate the brachial artery at the inner aspect of the elbow.
11. Place the earpieces of the stethoscope in your ears and place the diaphragm of the stethoscope over the brachial artery using your left hand.
12. Hold the rubber bulb in the palm of the hand not holding the stethoscope.

13. Quickly inflate the cuff with air by pumping the bulb to 170-200 mm Hg (for younger clients, inflate to 130-140 mm Hg). (CD-3)

14. Loosen the valve counterclockwise, deflate the cuff slowly and steadily. Listen carefully and watch the column of mercury or aneroid needle gauge for points where you hear the sound. (CD-4)

    NOTE: If you hear pulse sounds immediately, stop and deflate the cuff, wait 15 seconds. Inflate cuff to a higher calibration. (CD-5)

15. Note the systolic and diastolic reading.

16. Deflate the cuff completely when all sounds stop and remove it from the client's arm.

17. Do not reinflate the cuff during the reading; if you need to repeat procedure, you must let all the air out of the cuff and wait 30-60 seconds before inflating the cuff again.

18. Record blood pressure on paper.

Steps ending procedure

19. Remove, clean, and store equipment.

20. Wash your hands.

21. Make the client comfortable; place call signal within reach.

22. Record observations.

    Note: Report anything unusual to the charge nurse.

SUMMARY AND CONCLUSION:

1. Classroom discussion.

2. Review steps of procedure.

J. The long lines of the scale indicate one pound; each short line indicates one fourth pound. (HO 1)

III. Measuring a Client in Bed.

A. Client should be in supine position, with the bed flat.

B. Use a tape measure and measure from the top of the head to the soles of the feet.

IV. Measuring a Client on a Upright Scale

A. A height measurement rod is read in inches and the inches should then be converted to feet and inches.

B. 12 inches = 1 foot

48 inches = 4 feet

60 inches = 5 feet

72 inches = 6 feet

C. Measuring rod has long lines that indicate every one inch; short lines indicate one-fourth inch.

V. Reporting and Recording

A. Compare weight and height to previous record.

B. A gain or loss five pounds or more should be reported to the charge nurse.

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

VI. Steps of Procedure for Weighing and Measuring the Client

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

B. Steps of procedure to weigh and measure the client

6. Place a paper towel on the scale platform.
7. Raise the measuring rod.
8. Ask the client to remove robe and slippers; provide assistance if necessary.
9. Assist the client to stand on the scale platform; have client stand with arms to sides.
10. Read the weight.

    NOTE: If using a balance scale, move the weight until the pointer swings evenly between the top and bottom of the metal square.
11. Record weight.
12. Instruct the client to stand erect.
13. Lower the measuring rod until it rests on the client's head.
14. Read the height and record it on paper.
15. Assist client off of the platform. Assist client in putting on his/her robe and slippers, assist to his/her bed or chair.
16. Discard the paper towel.

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : RESTORATIVE NURSING

CLASSROOM DISCUSSION:

1. Why would you use a bed scales?
2. What is the best time of day to weigh a client?
3. What do you do if you weigh a client with an artificial leg?
4. If a client measures 58 inches, how many feet and inches is he/she? 63-1/2 inches? 74-1/4 inches?
5. How do you position the measuring rod when measuring a client?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates the procedure to weigh and measure a client.
2. Students practice weighing and measuring each other.

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

1. List two types of scales than can be used to weigh a client.

   a.

   b.

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____ 2. It is significant to always use the same scale when weighing the client.

_____ 3. The time of day is not important when weighing a client.

_____ 4. Always have the client eat breakfast before weighing to get the most accurate weight.

_____ 5. Remember to subtract the weight of an artificial limb or brace if the client is weighed with it on.

_____ 6. The long lines of the scale indicate 1/4 pound.

_____ 7. The client should be in a sitting position when measuring him/her in bed.

_____ 8. The measuring rod has long lines that indicate every one inch.

9. a. If a client measures 66 inches, how many feet and inches would he/she be?

   b. 57 1/4 inches?

   c. 63 3/4 inches?

10. How many pounds gained or lost are considered a significant amount that should be reported immediately?

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:
    a. Bathroom - portable
    b. Upright balance
    c. Chair - Hydraulic lift with sling
    d. Bed - stretcher
2. T
3. F
4. F
5. T
6. F
7. F
8. T
9. a. 5 ft. 6 in.
    b. 4 ft. 9 1/4 in.
    c. 5 ft. 3 3/4 in.
10. 5 lbs.

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing; measuring height; applying heat and cold; and preventing and caring for decubitus ulcers.; and caring for client's receiving oxygen therapy.

INFORMATION TOPIC: IX-65 OR DEMONSTRATION: IX-65

MEASURING WEIGHT AND HEIGHT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List two types of scales that can be used to weight a client.
2. Identify key points in weighing the client.
3. Identify key points in measuring a client in bed and on an upright scale.
4. Convert a measurement of inches into feet and inches.
5. Relate how much weight gain or loss in one month should be reported to the charge nurse.
6. Demonstrate how to weigh a client according to the steps of procedure.
7. Demonstrate how to measure a client according to the steps of procedure.

SUPPLEMENTARY TEACHING LEARNING ITEMS:

1. HO 1: Bathroom Scale, Platform Scale;
   A.S. 1: Assignment Sheet - read scale
2. Scale
3. Paper towel
4. Paper and pencil

TEACHER RESOURCES:

INTRODUCTION:

Clients are weighed upon admission to the long-term care facility and once a month, unless you are instructed to weigh the client more often by the charge nurse. A weight loss or gain can be significant and should be reported. The client's height is measured only once on admission since this does not usually change. As with many other procedures, accuracy is very important.

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Types of Scales

  A. Bathroom - portable

  B. Upright balance: Platform, platform with chair

  C. Chair - Hydraulic lift with sling

  D. Bed - stretcher

II. Weighing the Client

  A. Scales will vary from place to place in the facility. Always use the same scale when weighing the client.

  B. Balance the scale before weighing; bring the pointer on a bathroom scale to zero before any weight is placed on the scale.

  C. If you are unsure of how to balance the scale, ask for instructions before weighing the client.

  D. The weight of a person may vary during the day so perform the procedure at the same time each day.

  E. Clients should be weighed with their shoes off and with as little clothing on as possible.

  F. The best time to get an accurate weight is before the client has had anything to eat or drink in the morning; have the client urinate before weighing.

  H. If the client cannot stand and is in a wheel chair or geri chair, use a platform scale and weigh the chair first, then weight the client in the chair. Substract the weight of the chair. Some facilities may have a chair/platform scale - subtracting weight of chair is unnecessary.

  I. You may put a walker in place around the scale for the client to use when stepping on the scale for support.

C. Steps ending procedure

17. Remove, clean and store equipment.

18. Wash your hands.

19. Make the client comfortable; place call signal within reach.

20. Record observations.

NOTE: Report anything unusual to the charge nurse.

VII. Summary and Conclusion

A. Types of scales

B. Weighing the client

C. Measuring a client in bed

D. Measuring a client on an upright scale

E. Reporting and recording

F. Classroom discussion

G. Review steps of procedure

LESSON PLAN: 65

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT: ____________________

MEASURING WEIGHT AND HEIGHT

EQUIPMENT:

1. Scale
2. Paper towel
3. Paper and pencil

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain what he/she is going to do.		
5. Provide privacy.		
B. Procedure to weigh and measure the client		
6. Place a paper towel on the scale platform.		
7. Raise the measuring rod.		
8. Ask the client to remove robe and slippers; provide assistance if necessary.		

DID THE STUDENT			
9. Assist the client to stand on the scale platform; have resident stand with arms to sides.			
10. Read the weight.			
11. Record weight.			
12. Instruct the client to stand erect.			
13. Lower the measuring rod until it rests on the client's head.			
14. Read the height and record it on paper.			
15. Assist client off of the platform. Assist client in putting on his/her robe and slippers, assist to his/her bed or chair.			
16. Discard the paper towel.			
C. Steps ending procedure 17. Remove, clean, and store equipment.			
18. Wash hands.			
19. Make the client comfortable; place call signal within reach.			
20. Record observations and report anything unusual to the charge nurse.			

The student has satisfactorily completed the procedure "MEASURING WEIGHT AND HEIGHT" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 64

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT ____________________

MEASURING AND READING A BLOOD PRESSURE

EQUIPMENT:

1. Sphygmomanometer
2. Stethoscope
3. Alcohol sponges
4. Note pad and pencil

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Steps of procedure		
6. Position client seated or lying down with the entire lower arm on a flat surface, palm upward.		
7. Expose the arm as much as possible. Squeeze the cuff to expel any remaining air and turn the valve clockwise on the bulb to close it, using right hand thumb and forefinger.		
8. Wrap cuff snugly around the upper arm.		
9. Clean earpieces of stethoscope with alcohol sponge.		
10. Locate the brachial artery at the inner aspect of the elbow.		

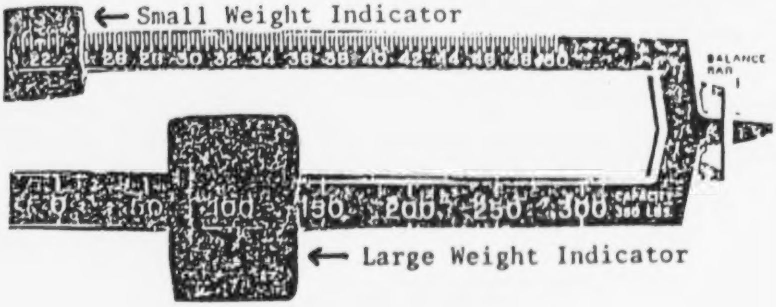
	YES	NO
11. Place the earpieces of the stethoscope in ears and place the diaphragm of the stethoscope over the brachial artery, using your left hand.		
12. Hold the rubber bulb in the palm of the hand not holding the stethoscope.		
13. Inflate the cuff.		
14. Loosen valve and deflate cuff.		
15. Note the systolic and diastolic reading.		
16. Deflate the cuff completely and remove from the client's arm.		
17. Let all the air out of the cuff and wait fifteen seconds before inflating the cuff again if procedure is to be repeated.		
18. Record blood pressure on paper.		
C. Steps ending procedure 19. Remove, clean, and store equipment.		
20. Wash hands.		
21. Make the client comfortable; place call signal within reach.		
22. Record observations and report anything unusual to the charge nurse.		

The student has satisfactorily completed the procedure "MEASURING AND READING A BLOOD PRESSURE" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

BATHROOM SCALE; PLATFORM SCALE; ASSIGNMENT SHEET


Small Weight Indicator
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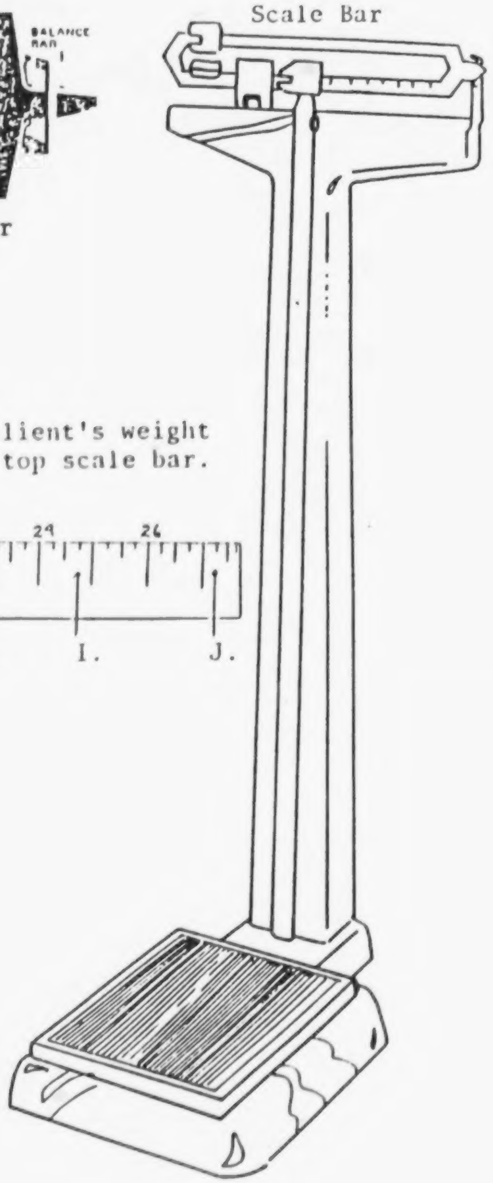
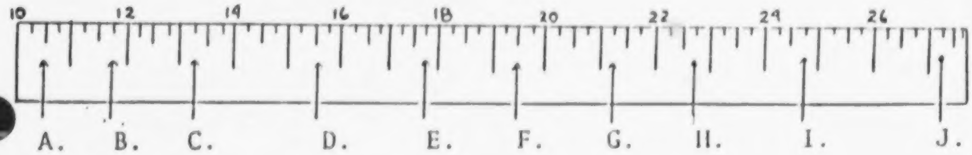
CAPACITY 350 LBS
Large Weight Indicator



If the large weight indicator is on 100, the client's weight would be 100 plus the weight indicated on the top scale bar.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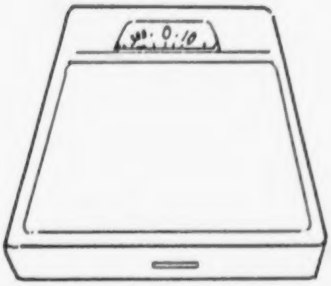


TEACHER RESOURCES:

INTRODUCTION:

Applications of heat and cold are ordered by the physician to promote healing and comfort and to reduce swelling. Heat and cold have opposite effects on the blood vessels. Applying heat/cold may be a responsibility of the NA. If so, it is important to keep in mind some basic principles and safety precautions in order to avoid injury or discomfort to the client.

3. Use crushed ice to fill the bag 2/3 full (it can be molded to the client's body part)

4. Should be placed in a flannel covering

5. Should be left in place for 30 minutes

6. Wait one hour and then reapply

VI. Complications of Cold Appliction (CD-5)

A. Cold temperature can result in tissue damage

1. Signs that indicate tissue damage

a. Pain
b. Cyanosis
c. Burns and blisters from intense cold
d. Blanching pallor

VII. Safety Measures to Follow when Applying Heat/Cold

A. Always check the temperature of a solution by using a thermometer or the inner aspect of your lower arm.

B. Check any type of electrical device to be sure the temperature control is properly set and that there are no frayed cords.

C. Make sure you know how to operate the equipment required for the procedure; if not, ask the charge nurse for instructions.

D. Check the skin every five minutes when heat/cold is applied for signs of complications.

E. Know how long the application is to be left in place and carefully monitor the time.

F. Expose only the body part where the heat/cold is to be applied.

G. Make sure the signal light is within easy reach of the client.

VIII. Summary and Conclusion

A. Purpose of heat application
B. Types of heat application
C. Complications of heat application
D. Purposes of cold application
E. Types of cold application
F. Complications of cold application
G. Safety measures to follow when applying heat or cold

LESSON PLAN: 66

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. How does increased blood flow promote healing?
2. What is the major complication from applying heat?
3. How often should the skin be checked when applying heat? or cold?
4. How does decreased blood flow prevent swelling/bleeding?
5. What kind of signs may indicate tissue damage from prolonged exposure to cold?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show filmstrip.
2. Show types of equipment used to apply heat/cold.

LESSON PLAN: 66

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

1. The purpose of heat is to: (Circle the letter of the correct answer.)

    a. Dilate blood vessels; increase blood flow
    b. Dilate blood vessels; decrease blood flow
    c. Constrict blood vessels; increase blood flow
    d. Constrict blood vessels to stop blood flow

2. List three uses for heat.

    a.

    b.

    c.

3. Heat can be applied by which of the following methods? (Circle the letter of the correct answer.)

    a. Heat lamp
    b. Hot water bottle
    c. Heating pad
    d. All of the above

4. Which of the following is not a sign that would indicate a complication of heat? (Circle the letter of the correct answer.)

    a. Reddened appearance
    b. Chilling
    c. Blisters
    d. Pain at the site

5. The purpose of cold is to: (Circle the letter of the correct answer.)

    a. Dilate blood vessels; increase blood flow
    b. Constrict blood vessels; decrease blood flow
    c. Constrict blood vessels; increase blood flow
    d. Dilate blood vessels; decrease blood flow

6. List three uses for cold application.

a.

b.

c.

7. Which of the following is not a method of applying cold? (Circle the leter of the correct answer.)

a. Cold compresses
b. Ice bag
c. Cold sponge bath
d. Tepid bath

8. Which of the following is not a sign that would indicate a complication of cold? (Circle the letter of the correct answer.)

a. Pain
b. Cyanosis
c. Blisters
d. Reddened appearance

For each of the following, write "T" if the statment is true, or "F" if it is false.

______ 9. Never apply a solution for heat and cold application without checking the temperature first.

______ 10. Expose only the area to be treated with heat/cold.

______ 11. Make sure the signal light is within easy reach of the client when applying heat/cold.

LESSON PLAN: 66

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. a

2. a. Relieve pain by relaxing muscles
   b. Reduce inflammation
   c. Provide warmth and comfort

3. d

4. b

5. b

6. a. Reduce pain - numbing effect
   b. Prevent swelling
   c. Cool the body when fever is present

7. d

8. d

9. T

10. T

11. T

LESSON PLAN: 67

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-67

APPLYING A WARM MOIST COMPRESS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to apply a warm moist compress according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Applying a Warm Moist Compress
2. Basin
3. Bath thermometer
4. Compress - small towel, washcloth, or gauze squares
5. Plastic wrap
6. Ties, tape, or rolled gauze
7. Bath towel
8. Waterproof bed protector

TEACHER RESOURCES:

INTRODUCTION:

A compress is a small towel, gauze square or washcloth which is applied to a small area of the body. This procedure will only be performed by the NA if the skin is intact and it is not considered a sterile procedure. The charge nurse would be responsible for that type of compress. Make pertinent observations when applying this type of heat.

LESSON PLAN: 67

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE:

Applying a Warm Moist Compress

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

Warm moist compress procedure

6. Position client in a comfortable position.
7. Place waterproof bed protector under the body part that is to receive moist compress.
8. Fill basin 1/2 to 2/3 full with hot water that is 105 to 115°F.
9. Place compress into hot water.
10. Wring out compress so water is not dripping from it.
11. Apply to specified area and note time of application.
12. Cover compress with a plastic wrap and then with a bath towel. (CD-1)
13. Secure towel in place with ties, tape or rolled gauze.

    NOTE: May apply warm water bottle/heating pad if ordered. (CD-2)
14. Make sure signal light is within reach; check area every five minutes; change compress if cooling occurs.
15. Remove moist compress after 20 minutes; pat dry with a towel. (CD-3)

Steps ending procedure

16. Remove, clean, and store equipment.

17. Wash your hands.

18. Make the client comfortable; place call signal within reach.

19. Record observations.

    NOTE: Report anything unusual to the charge nurse.

SUMMARY AND CONCLUSION:

1. Classroom discussion.

2. Review steps of procedure.

LESSON PLAN: 66

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-66 OR DEMONSTRATION:

APPLYING HEAT AND COLD
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the purpose of applying heat.
2. List three uses for heat application.
3. Recognize three types of heat application.
4. Identify signs of complications of heat application.
5. Identify the purpose of applying cold.
6. List three uses for cold application.
7. Recognize three types of cold application.
8. Identify signs of complications of cold application.
9. Recognize safety measures to follow when applying heat/cold.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex filmstrip: "The Application of Heat and Cold"
2. Projector
3. Heat lamp
4. Hot water bottle
5. Heating pad
6. Ice bag

LESSON PLAN: 66

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points

I. Purpose of Heat Application (CD-1)

   A. The purpose of heat is to cause the blood vessels to dilate where applied; more blood flow increases the amount of oxygen and nutrients to the area which will promote tissue healing.

   B. Dilation of blood vessels also speeds up removal of waste products, poisonous substances, and excess fluid from the area.

   C. Uses

      1. Relieve pain, as in muscular spasm, by relaxing muscles.

      2. Reduce inflammation

      3. Provide warmth and comfort

II. Types of heat application

   A. Warm compresses - moist heat

   B. Heat lamp - dry heat

   C. Hot water bottle

      1. Dry heat

      2. Check bag for leaks before applying

      3. Fill 1/2 full

      4. Expel air

      5. Cover with flannel bag before applying

   D. Heating pad - dry heat

   E. Warm soaks - moist heat

III. Complications of Heat Applications (CD-2)

A. High temperature can result in burns; remember the skin of the young and elderly is more fragile and easily damaged; check every five minutes.

B. Complications may also occur in clients with poor sensation, circulation problems or those who are confused.

C. Signs that indicate burns

1. Pain or sensitivity at the site of application
2. Site appears very reddened or darkened
3. Blisters
4. Any of these signs would indicate to discontinue teatment immediately and report to the charge nurse.

IV. Purpose of Cold Application

A. The purpose of cold is to cause the blood vessels to constrict when applied; less blood flow decreases the amount of oxygen and nutrients to the area which will reduce the amount of toxic substances and waste products produced. (CD-4)

B. Uses

1. Reduce pain, has numbing effect
2. Prevent swelling
3. Cool the body when fever is present
4. Control bleeding

V. Types of Cold Application

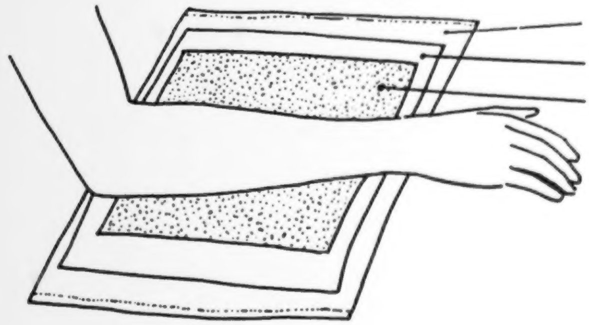
A. Cold compresses - moist cold

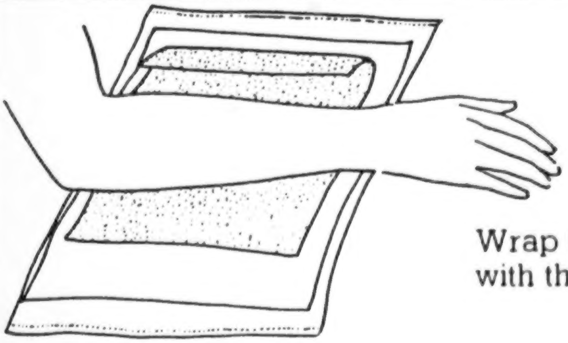
B. Cold sponge bath - moist cold

C. Ice bag

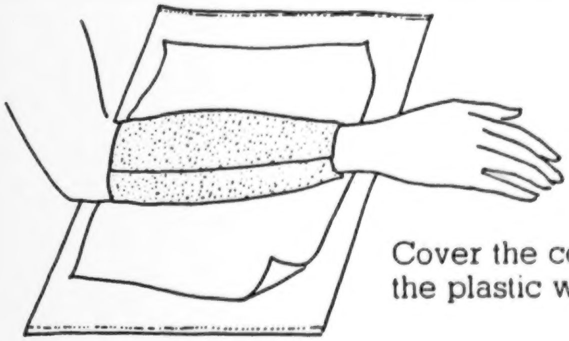
1. Dry cold
2. Check for leaks before filling

APPLYING A WARM MOIST COMPRESS


Towel
Plastic wrap
Compress that has been wrung out

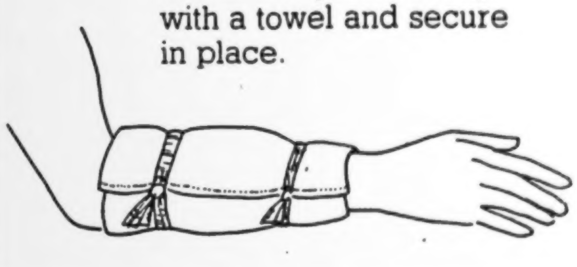


Wrap the extremity with the compress.



Cover the compress with the plastic wrap.

Cover the plastic wrap with a towel and secure in place.



Check the skin under the heat application for:

- Too much redness
- Discoloration of the skin
- If you think the patient is being burned, discontinue treatment

Report to the nurse immediately

LESSON PLAN: 67

COURSE TITLE: NURSE ASSISTANT

UNIT IX: SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. After applying the compress, what should you put over it?
2. What could you put on top of the area to provide additional heat?
3. How long do you leave a moist compress on?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates applying warm moist compress.
2. Students demonstrate applying warm moist compress.

LESSON PLAN: 67

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT ____________________

APPLYING A WARM MOIST COMPRESS

EQUIPMENT:

1. Basin
2. Bath thermometer
3. Compress - small towel, washcloth or gauze squares
4. Plastic wrap
5. Ties, tape, or rolled gauze
6. Bath towel
7. Waterproof bed protector

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Steps of procedure		
6. Position client in a comfortable position.		
7. Place waterproof bed protector under the body part that is to receive moist compress.		
8. Fill basin 1/2 to 2/3 full with hot water that is 100 to 115 °F.		

	YES	NO
9. Place compress into hot water.		
10. Wring out compress so water is not dripping from it.		
11. Apply to specified area and note time of application.		
12. Cover compress with a plastic wrap and then with a bath towel.		
13. Secure towel in place with ties, tape or rolled gauze.		
14. Make sure signal light is within reach; check area every five minutes; change compress if cooling occurs.		
15. Remove moist compress after 20 minutes; pat dry with a towel.		
C. Steps ending procedure		
16. Remove, clean, and store equipment.		
17. Wash hands.		
18. Make the client comfortable; place call signal within reach.		
19. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "APPLYING A WARM MOIST COMPRESS" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 68

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; and preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-68

APPLYING A WARM WATER BOTTLE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to apply a warm water bottle according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Warm water bottle
2. Cover (flannel)
3. Towel
4. Bath thermometer
5. Water - 100° to 115° F
6. Graduate

TEACHER RESOURCES:

INTRODUCTION:

Heat relieves inflammation by vasodilation (increasing circulation). It reduces discomfort due to chilling and relaxes muscles, tendons and ligaments. We have discussed the use of the warm water bottle and the principles of safety to be considered when applying heat. Always test warm water bottles for leaks before filling them. The temperature of the water should be between 100° - 115° F. Today you will learn how to properly fill and administer this heat treatment, keeping first in mind the client's safety and comfort.

LESSON PLAN: 68

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE

Applying a Warm Water Bottle.

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

Warm water bottle procedure

6. Rinse warm water bottle with hot tap water; test for leaks. (CD-1)
7. Fill graduate with warm water and test temperature with bath thermometer (110 - 115). (CD-2)
8. Pour warm water into bag until approximately 1/2 full. (CD-3)
9. Expel air from bottle.
10. Close opening.
11. Dry top and neck of bottle.
12. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.
13. Apply as ordered.
14. Record time, temperature of water and area to which it is applied.
15. Make sure signal light is within reach; check client's skin area and dryness of warm water bottle; cover every thirty minutes to prevent burns. (CD-4)

16. Refill warm water bottle as often as necessary to retain desired heat.

Steps ending procedure

17. Remove, clean, and store equipment.
    a. Dry inside and outside of bottle.
    b. Hang upside down with cap off.
    c. Store, inflated, in cool place.

18. Wash your hands.

19. Make client comfortable; place call signal within reach.

20. Record observations.

NOTE: Report anything unusual to charge nurse.

SUMMARY AND CONCLUSION:

1. Classroom discussion.

2. Review steps of procedure.

LESSON PLAN: 68

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION

1. What should you do before filling a warm water bottle?
2. What should be the temperature of the water that fills the warm water bottle?
3. How full should the bag be filled?
4. How often should the client be checked?
5. How often should the warm water bottle be filled?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates applying warm water bottle.
2. Students practice applying warm water bottle.

LESSON PLAN: 68

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT ____________

APPLYING A WARM WATER BOTTLE

EQUIPMENT:

1. Warm water bottle
2. Cover (flannel)
3. Towel
4. Bath thermometer
5. Water - 110° to 115° F
6. Graduate

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Steps of procedure		
6. Rinse warm water bottle with hot tap water; test for leaks.		
7. Fill graduate with warm water and test temperature with bath thermometer (110°- 115° F).		
8. Pour warm water into bag until approximately 1/2 full.		

	YES	NO
9. Expel air from bottle.		
10. Close opening.		
11. Dry top and neck of bottle.		
12. Apply flannelette cover or wrap in dry towel to prevent burns and to secure in place.		
13. Apply as ordered.		
14. Record time, temperature of water, and area to which it is applied.		
15. Make sure signal light is within reach; check client's skin area and dryness of warm water bottle cover every thirty minutes to prevent burns.		
16. Refill warm water bottle as often as necessary to retain desired heat.		
C. Steps ending procedure 17. Remove, clean, and store equipment. a. Dry inside and outside of bottle. b. Hang upside down with cap off. c. Store inflated in cool place.		
18. Wash hands.		
19. Make client comfortable; place call signal within reach.		
20. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "APPLYING A WARM WATER BOTTLE" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 69

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing; measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-69

APPLYING AN ICE BAG OR ICE CAP
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to apply an ice bag or ice cap according the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Ice cap
2. Ice bag and wrapper
3. Ice

TEACHER RESOURCES:

INTRODUCTION:

We have discussed reasons for applying heat applications. An ice cap or ice bag may be ordered for several reasons - perhaps to relieve pain and reduce swelling, to control bleeding or to lower the body temperature. Whatever the reason for cold application, it is important to keep in mind the safety and comfort of the client. Since frostbite and damage to the lower body tissues could result from too long an application, it becomes necessary to observe the client's skin condition every twenty minutes. Cold application should be discontinued at two hour intervals or as the physician orders. You will now learn how to fill an ice cap or bag.

LESSON PLAN: 69

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE:

Applying an Ice Bag or Ice Cap

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

Ice bag/ice pack procedure

6. Test equipment for leaks by filling with water.

   NOTE: This is done outside the client's room, usually in the dirty utility room.

7. Use clean basin, scoop, or spoon to collect ice.
8. Fill ice cap or ice bag 1/2 to 2/3 full. (CD-1)
9. Expel all air by placing bag on flat surface and pressing down over the ice and the air pocket around the opening.
10. Dry outside of bag or cap. If moisture is left on the bag, it may penetrate and cause injury. (CD-2)
11. Apply cover (fitted wrapper or towel pinned around equipment).
12. Apply to indicated area.
13. Check every 20 minutes for skin reactions. (CD-3)
14. Remove cap or bag when time has elapsed or refill equipment, if necessary.
15. Application discontinued at two hour intervals or per physician's order. (CD-4)

Steps ending procedure

16. Remove, clean, and store equipment.
    - a. Dry exterior.
    - b. Hang upside-down without cap closing.
    - c. Store appliance inflated and closed in a cool place after drying.
17. Wash your hands.
18. Make client comfortable; place call signal within reach.
19. Record observations.

    NOTE: Report anything unusual to charge nurse.

SUMMARY AND CONCLUSION:

1. Classroom Discussion.
2. Review steps of procedure.

LESSON PLAN: 69

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. How full should you fill the ice bag?
2. Why should you dry the ice bag?
3. How often should the client be checked when he/she has on an ice bag?
4. How often should application be discontinued?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates applying an ice bag/ice cap.
2. Students demonstrate applying an ice bag/ice cap.

LESSON PLAN: 69

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT ____________

APPLYING AN ICE BAG OR ICE CAP

EQUIPMENT:

1. Ice Cap
2. Ice bag and wrapper
3. Ice

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Steps of procedure		
6. Test equipment for leaks by filling with water.		
7. Use clean basin, scoop, or spoon to collect ice.		
8. Fill ice cap or ice bag 1/2 to 2/3 full.		
9. Expel all air from bag.		

	YES	NO
10. Dry outside of bag or cap.		
11. Apply cover (fitted wrapper or towel pinned around equipment).		
12. Apply to indicated area.		
13. Check every 20 minutes for skin reactions.		
14. Remove cap or bag when time has elapsed or refill equipment if necessary.		
15. Application discontinued at 2 hour intervals or per physician's order.		
15. Make sure signal light is within reach; check client's skin area and dryness of warm water bottle cover every thirty minutes to prevent burns.		
C. Steps ending procedure		
16. Remove, clean, and store equipment. a. Dry exterior. b. Hand upside-down without cap closing. c. Store inflated when dry.		
17. Wash hands.		
18. Make client comfortable; place call signal within reach.		
20. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "APPLYING AN ICE BAG OR ICE CAP" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

LESSON PLAN: 70

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: OR DEMONSTRATION: IX-70

APPLYING A HEAT LAMP
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Demonstrate how to apply a heat lamp according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Heat lamp
2. Bath blanket
3. Bath towel
4. Tape measure

TEACHER RESOURCES:

INTRODUCTION:

A heat lamp is a good way to promote circulation to an area; it is also useful to dry draining wounds such as a decubitus ulcer. A variety of heat lamps are available; a gooseneck type lamp is most common since it is flexible, allowing for various positions. Never put linen over a heat lamp which would constitute a fire hazard.

LESSON PLAN: 70

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

STEPS OF PROCEDURE:

Applying a Heat Lamp

Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Provide privacy.

Heat lamp procedure

6. Plug in the lamp and allow it to warm up.
7. Cover client with a bath blanket and fanfold top linens to foot of bed. (CD-1)
8. Expose body area that is to receive the heat.
9. Position the heat lamp so that it is a safe distance from the skin depending on wattage of light bulb, use tape measure to check the distance.

   NOTE: 40 watt bulb - 18 inches away
   60 watt bulb - 24 inches away (CD-2)

10. Note time of application.
11. Place call signal within the client's reach.
12. Check the client every five minutes to observe skin. (CD-3)
13. Remove heat lamp when treatment is completed. Return top linens to proper position and remove bath blanket.

    NOTE: Length of treatment is usually 20 minutes.

Steps ending procedure

14. Remove, clean, and store equipment.

15. Wash your hands.

16. Make the client comfortable; place call signal within reach.

17. Record observations.

    NOTE: Report anything unusual to the charge nurse.

SUMMARY AND CONSLUSION:

1. Classroom Discussion.

2. Review steps of procedures.

LESSON PLAN: 70

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. With what should you cover the client?
2. If using a 40 watt bulb, how far should the lamp be placed from the body? 60 watt bulb?
3. How often should the client be checked?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Instructor demonstrates procedure of applying a heat lamp.
2. Students practice procedure of applying a heat lamp.

LESSON PLAN: 70

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT________________________

APPLYING A HEAT LAMP

EQUIPMENT

1. Heat lamp
2. Bath blanket
3. Bath towel
4. Tape Measure

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Provide privacy.		
B. Steps of procedure		
6. Plug in the lamp and allow it to warm up.		
7. Cover client with a bath blanket and fanfold top linens to foot of bed.		
8. Expose body area that is to receive the heat.		

	YES	NO
9. Position the heat lamp so that it is a safe distance from the skin depending on wattage of light bulb, use tape measure to check the distance		
10. Note time of application.		
11. Place call signal within the client's reach.		
12. Check the client every five minutes to observe skin.		
13. Remove heat lamp when treatment is completed. Return top linens to proper position and remove bath blanket.		
C. Steps ending procedure 16. Remove, clean, and store equipment.		
17. Wash hands.		
18. Make client comfortable; place call signal within reach.		
20. Record observations and report anything unusual to charge nurse.		

The student has satisfactorily completed the procedure "APPLYING A HEAT LAMP" according to the steps outlined.

____
Instructor's signature
(Verifying Satisfactory Completion)

____
Date

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; and preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-71 OR DEMONSTRATION: IX-71

PREVENTING AND CARING FOR DECUBITUS ULCERS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Describe the main cause of decubitus ulcers.
2. List four pressure areas.
3. Identify three clients prone to formation of decubitus ulcers.
4. List three early signs of a decubitus ulcer.
5. List observations that should be made about a decubitus ulcer.
6. Give decubitus care according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Pressure Areas
2. Trainex filmstrip #185: "Prevention and Treatment of Decubitus Ulcers"
3. Concept Media: "Pressure", Parts 1 and 2
4. Projector and Screen
5. Lotion
6. Heel and elbow pads
7. Sheepskin
8. Air or water mattress

TEACHER RESOURCES:

INTRODUCTION:

A decubitus ulcer is sometimes referred to as a pressure sore or a bedsore. It is one of the worst things that can happen to a client. The nurse assistant must remember that most decubitus ulcers can be prevented with good nursing care. There are rare situations where clients are in such condition that even the best nursing care is not enough.

Keep in mind that as the NA you can play a major role in the prevention of decubiti from developing. The NA will not be responsible for changing the dressing over a decubitus buy may be asked to help the charge nurse during the procedure.

The following lesson will inform you of proper care and preventive measures of decubitus ulcers.

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Decubitus Ulcers

A. A decubitus ulcer is an inflammation, sore, or lesion that develops over areas where the skin and tissue underneath are injured due to a lack of blood flow.

B. This lack of circulation usually happens because of continuous pressure on the skin over a bony prominence resulting from the way or length of time a client is positioned. (CD-1)

C. Pressure is the main cause; other things such as heat, friction, moisture and irritating substances, such as hairpins/crumbs can hasten the development of sores.

D. Pressure areas (HO 1)

1. Back of ear
2. Back of head
3. Shoulder blade
4. Back bone
5. Elbow
6. Crest of pelvis
7. Hip bone
8. Coccyx region
9. Buttocks
10. Knee cap
11. Outside of ankle
12. Inside of ankle
13. Heel

        b. Air mattress - keeps pressure off half the body at a time; do not use pins or any sharp object near mattress

        c. "Sheepskin" - keeps skin dry with air circulating through "wool"; spreads pressure evenly

        d. Egg carton pad - distributes pressure evenly

        e. Pillows - provide support

        f. Overbed cradle - keeps weight of top linen off client

        g. Waterbed - distributes pressure evenly

        h. Other

C. Promote good circulation.

    1. Use gentle massage over bony prominences and reddened areas.

    2. Passive and active exercises to stimulate circulation.

D. Promote good skin condition.

    1. Keep skin clean and dry.

        a. Change wet/soiled linens immediately.

        b. Wash peri area and dry thoroughly.

    2. Keep bed linen dry and free of wrinkles and any other irritating substance.

    3. Try to prevent incontinence.

        a. Reinforce bowel/bladder training.

    4. Encourage good nutrition (protein, vitamins, and minerals) and fluid intake.

    5. Avoid injury to the skin.

E. Prevent friction on the client's skin by avoiding:

    1. Wrinkles in bed sheet

2. Pulling a client up in bed/chair and dragging over sheets/pads instead of lifting

3. Vigorous rubbing/massaging of skin

V. Observations to Make about Decubitus Ulcers

A. Location of the decubitus ulcer - "right inner ankle"

B. Condition of the skin - "reddened area"

C. Size of the decubitus ulcer - "about the size of a nickel"

D. Skin temperature - "warm to touch"

E. Any treatment you performed - "massaged area gently"

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

VI. STEPS OF PROCEDURE FOR DECUBITUS CARE -(intact skin only)

A. Steps beginning procedure

1. Wash your hands.
2. Assemble necessary equipment.
3. Identify and greet client. Identify self.
4. Explain what you are going to do.
5. Raise bed to the horizontal position that is comfortable for you.

B. Decubitus care procedure.

5. Check turning schedule.
6. Observe reddened area.
7. Wash skin area with soap and water if soiled.
   a. Use disposable gloves
8. Rub skin with lotion.
9. Rub gently from the outer area of redness to the center with a circular motion. (CD-3)
10. Place clean linen on bed if necessary.
11. Tighten linen (remove all wrinkles).
12. Turn client to side listed on turning schedule.
13. Lower bed to a position of safety for the client.

C. Steps ending procedure

14. Remove, clean and store equipment.

15. Wash your hands.

16. Record observations.

17. Record care given, time given and side to which client was turned.

NOTE: Report anything unusual to the charge nurse.

VII. Summary and Conclusion

A. Decubitus ulcers

B. Clients prone to forming decubitus ulcers

C. Indications of decubitus ulcers

D. Prevention of decubitus ulcers

E. Observations to make about decubitus ulcers

F. Classroom Discussion

G. Review steps of procedure.

A decubitus ulcer or bedsore can be as harmful to the human body as major surgery. It it worth every effort to prevent it. For every minute it takes to cause a decubitus it takes weeks to heal. Remember the basic prevention and treatment techniques are simply stimulating circulation, avoiding pressure on one area for a long period of time and keeping the skin clean and dry at all times.

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. What are some of the bony prominences?
2. Have you ever tried to sit lay/motionless for two hours?
3. How do you rub a reddened area of the skin when performing decubitus care?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students antipressure devices.
2. Show filmstrips.
3. Instructor demonstrates decubitus care procedure.
4. Students practice steps in decubitus care procedure.

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

1. Describe the main cause of decubitus ulcers:

2. List four pressure areas.

   a.

   b.

   c.

   d.

3. Which of the following describes a client prone to developing decubitus? Mark the correct answer(s) with a check (X).

   _____a. Independently ambulatory client

   _____b. Thin and malnourished client

   _____c. Paralyzed client

   _____d. Incontinent client

   _____e. Obese client

4. List three early signs of a decubitus ulcer.

   a.

   b.

   c.

5. Which of the following is not a necessary measure to prevent decubitus? (Circle the letter of the correct answer).

   a. Promote good circulation
   b. Promote friction on the client's skin
   c. Prevent pressure
   d. Promote good skin condition

6. What five observations should be made when taking care of a client with a decubitus ulcer?

a.

b.

c.

d.

e.

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. Pressure is the main cause--it impairs circulation and skin and tissue underneath the point of pressure is injured.

2. The student may list any four of the following:

   a. Back of ear
   b. Back of head
   c. Shoulder blade
   d. Back bone
   e. Elbow
   f. Crest of pelvis
   g. Hip bone
   h. Coccyx region
   i. Buttocks
   j. Knee cap
   k. Outside of ankle
   l. Inside of ankle
   m. Heel

3. Student should check b, c, d, and e.

4. The student may list any three of the following:

   a. Redness and tenderness of the area (but no break in the skin) which does not go away with gentle massage
   b. Complaints of a burning sensation
   c. Coldness of the area; bluish-grey color
   d. Presence of edema

5. b

6. a. Location of the decubitus ulcer
   b. Condition of the skin
   c. Size of the decubitus ulcer
   d. Skin temperature
   e. Any treatment performed

LESSON PLAN: 71

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS: NAME OF STUDENT: ______________

GIVE DECUBITUS CARE

EQUIPMENT:

1. Lotion
2. Heel and elbow pads
3. Sheepskin
4. Air or water mattress

DID THE STUDENT	YES	NO
A. Steps beginning procedure		
1. Wash hands.		
2. Assemble necessary equipment.		
3. Identify and greet client. Identify self.		
4. Explain procedure to client.		
5. Raise bed to horizontal working height		
B. Decubitus care procedure		
6. Check turning schedule		
7. Observe reddened area. 8. Wash skin area with soap and water if soiled.		
9. Rub skin with lotion.		

	YES	NO
10. Rub gently from the outer area of redness to the center with a circular motion.		
11. Place clean linen on bed if necessary.		
12. Tighten linen (remove all wrinkles)		
13. Turn client to side listed on turning schedule		
C. Steps ending procedure 15. Remove, clean, and store equipment.		
16. Wash hands.		
17. Record obsevations and report anything unusual to the charge nurse.		
18. Record care given, time given, and side to which client was turned.		

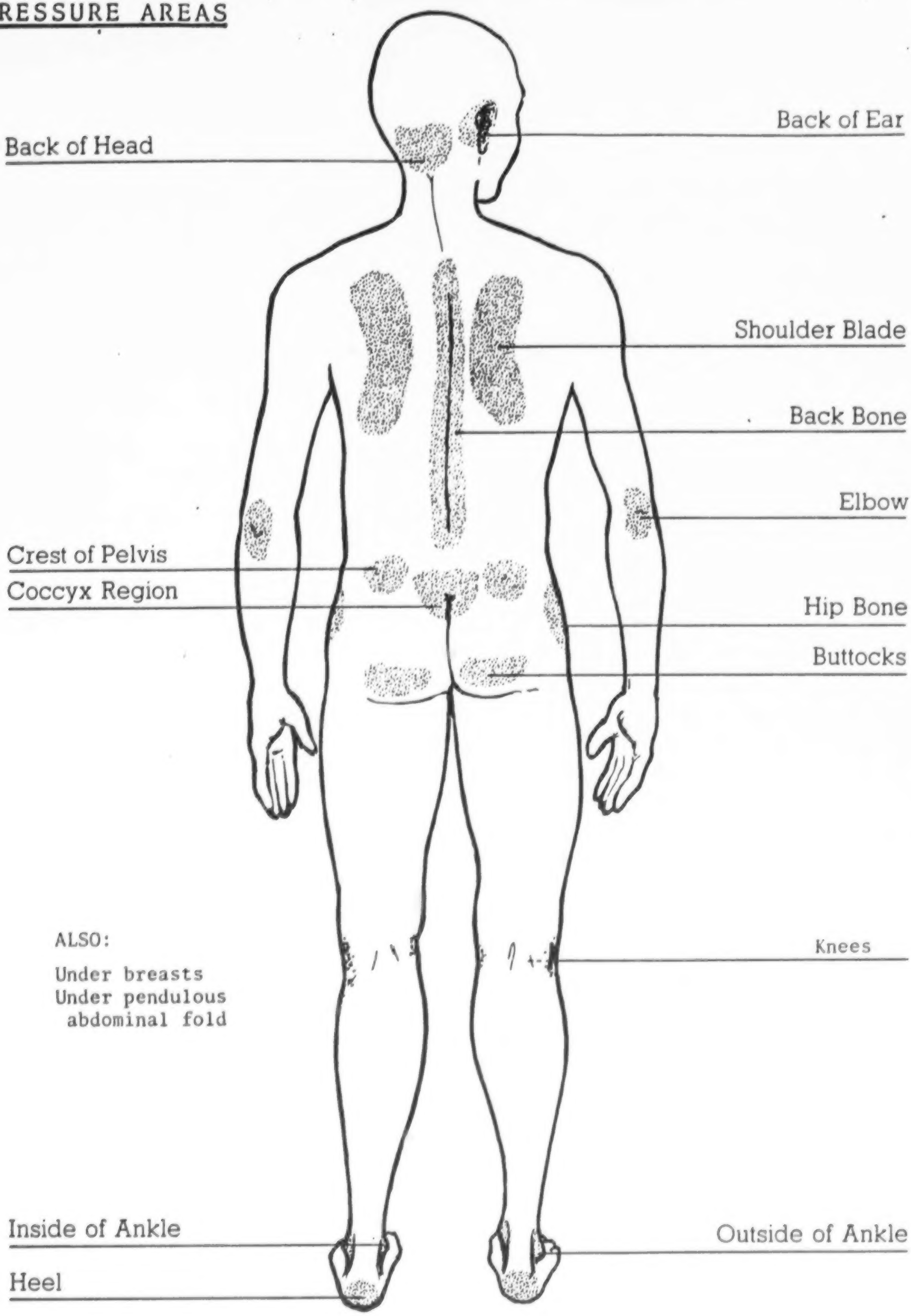
The student has satisfactorily completed the procedure "GIVE DECUBITUS CARE" according to the steps outlined.

Instructor's signature
(Verifying Satisfactory Completion)

Date

PRESSURE AREAS

HO 1


Back of Ear
Back of Head
Shoulder Blade
Back Bone
Elbow
Crest of Pelvis
Coccyx Region
Hip Bone
Buttocks
Knees
Inside of Ankle
Heel
Outside of Ankle

ALSO:

Under breasts
Under pendulous
abdominal fold

LESSON PLAN: 72

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

SCOPE OF UNIT:

This unit covers special procedures which include: admission; in-house transfer and discharge of the client; measuring vital signs; weighing, measuring height; applying heat and cold; preventing and caring for decubitus ulcers; and caring for clients receiving oxygen therapy.

INFORMATION TOPIC: IX-72 OR DEMONSTRATION:

OXYGEN THERAPY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List two types of oxygen containers.
2. List two methods of administering oxygen.
3. Identify five safety measures to follow when administering oxygen.
4. Recognize five comfort measures to follow when administering oxygen.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Oxygen tank
2. Plastic mask
3. Nasal cannula

TEACHER RESOURCES:

INTRODUCTION:

Oxygen is a colorless, odorless, tasteless gas that is absolutely necessary to life. Because of a disease or condition, the client may not be able to take in enough oxygen on his/her own by breathing.

Oxygen is considered a drug. The doctor must order it to be administered. The licensed person will be responsible for the administration of oxygen; however, the Nurse Assistant will be assigned to take care of clients who are receiving oxygen and should be familiar with the equipment used and basic safety and comfort measures to follow.

II. Clients Prone to Forming Decubitus Ulcers

  A. Elderly clients - due to sluggish circulation, poor nutrition, lack of exercise/mobility

  B. Paralyzed clients - because of sensory deficit, lack of mobility

  C. Thin and malnourished clients - bony prominence is closer to skin surface

  D. Obese clients - skin in contact with skin can break down; example: underneath the breasts, between legs, and abdominal folds

  E. Incontinent clients - constant dampness irritates the skin

III. Indications of Decubitus Ulcers

  A. Stage I - early signs

    1. Redness and tenderness of the area (but no break in skin) which does not go away with gentle massage

    2. Complaints of a burning sensation

    3. Coldness of the area, bluish-grey color

    4. Presence of edema

  B. Stage II - skin becomes bluish, mottled or dusky color; top layer of skin is broken or blistered

  C. Stage III - breakdown of deep layers of the skin; open sore

IV. Prevention of Decubitus Ulcers

  A. Determine which clients are prone to developing sores and check their skin condition frequently.

  B. Prevent pressure.

    1. Change the client's position frequently at least every two hours. (CO-2)

    2. Turning should be scheduled for helpless client.

    3. Use antipressure devices.

      a. Alternating air pressure - cover with only one sheet and draw sheet to avoid additional layers of material between client and mattress

F. Check that face mask is snug and not allowing oxygen to be ineffective.

G. Observe for any signs and symptoms that client is not getting enough oxygen.

1. Client feels like he/she "can't breathe"
2. Restlessness, irritability, anxious or frightened
3. Decreased muscle coordination and slowed mental abilities
4. Dyspnea, cyanosis
5. Increased rate and depth of respirations
6. Client complains of dizziness or faintness (CD-3)

IV. Summary and Conclusion

A. Oxygen equipment

B. Safety measures

C. Comfort measures

The nurse assistant's role in oxygen therapy is to make pertinent observations. Clients receiving oxygen may not be a common occurrence in every facility, but all nurse assistants should have an understanding of how dangerous this can be if not handled properly and what he/she can do to keep the client comfortable while receiving oxygen.

LESSON PLAN: 72

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

CLASSROOM DISCUSSION:

1. What ways have you seen oxygen administered?
2. Why is it necessary to humidify oxygen?
3. If you noted signs of the client not getting enough oxygen, what should you do?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Show students different equipment used in oxygen therapy.

Subtitle C—Nursing Home Reform

PART 1—MEDICARE PROGRAM

SEC. 4201. REQUIREMENTS FOR SKILLED NURSING FACILITIES.

(a) SPECIFICATION OF FACILITY REQUIREMENTS.—Title XVIII of the Social Security Act is amended—

(1) by amending subsection (j) of section 1861 (42 U.S.C. 1395x) to read as follows:

"Skilled Nursing Facility

"(j) The term 'skilled nursing facility' has the meaning given such term in section 1819(a).";

(2) by adding at the end of section 1864 (42 U.S.C. 1395aa) the following new subsection:

"(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e)."; and

(3) by adding at the end of part A the following new section:

"(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

"(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

"(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and residents' rights), content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

"(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, residents' rights, and procedures for determination of competency; and

"(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs.

"(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

"(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

"(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

"(iii) shall prohibit approval of such a program—

"(I) offered by or in a skilled nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d), within the previous 2 years, or

"(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate its responsibility under clause (iii)(II) to the skilled nursing facility.

PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

(a) SPECIFICATION OF FACILITY REQUIREMENTS.—Title XIX of the Social Security Act is amended—

(1) by redesignating section 1922 as section 1923,

(2) by redesignating section 1919 as section 1922 and by transferring and inserting such section after section 1921, and

(3) by inserting after section 1918 the following new section:

"(5) REQUIRED TRAINING OF NURSE AIDES.

"(A) IN GENERAL.—A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual, who is not a licensed health professional (as defined in subparagraph (E)), as a nurse aide in the facility on or after January 1, 1990, for more than 4 months unless the individual—

"(i) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

"(ii) is competent to provide such services.

"(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide, for individuals used as a nurse aide by the facility as of July 1, 1989, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

"(C) COMPETENCY.—The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of the State registry established under subsection (e)(2)(A) as to information in the registry concerning the individual.

"(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program.

"(E) REGULAR IN-SERVICE EDUCATION.—The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

"(F) NURSE AIDE DEFINED.—In this paragraph, the term 'nurse aide' means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

"(i) who is a licensed health professional (as defined in subparagraph (G)), or

"(ii) who volunteers to provide such services without monetary compensation.

THE COMMON CORE

ATTRIBUTES AND ATTITUDES

A positive self-image and self-esteem are crucial to learning. These attributes determine goals, behaviors and responses to others. Furthermore, people depend on and influence one another. Therefore, it is important that students take responsibility for their lives and set appropriate goals for themselves. In doing so, they develop lifelong attitudes.

The family and societal forces other than schools play major roles in fostering student growth, and schools can provide a supportive climate for that growth. While it is inappropriate for schools to accept the sole or even primary responsibility for developing these attributes and attitudes, it is also inappropriate to deny the critical importance of these factors as preconditions to learning, as consequences of the teaching of all disciplines, and as desired outcomes for all students.

Positive Self-Concept

As part of education in grades K-12, each student should be able to:

1. appreciate his/her worth as a unique and capable individual and exhibit self-esteem;
2. develop a sense of personal effectiveness and a belief in his/her ability to shape his/her future;
3. develop an understanding of his/her strengths and weaknesses and the ability to maximize strengths and rectify or compensate for weaknesses.

Motivation and Persistence

As part of education in grades K-12, each student should be able to:

1. experience the pride of accomplishment that results from hard work and persistence;
2. act through a desire to succeed rather than a fear of failure, while recognizing that failure is a part of everyone's experience;
3. strive toward and take the risks necessary for accomplishing tasks and fulfilling personal ambitions.

Reponsibility and Self-Reliance

As part of education in grades K-12, each student should be able to:

1. assume the primary responsibility for identifying his/her needs and setting reasonable goals;
2. initiate actions and assume responsibility for the consequences of those actions;
3. demonstrate dependability;
4. demonstrate self-control.

Intellectual Curiosity

As part of education in grades K-12, each student should be able to:

1. demonstrate a questioning attitude, open-mindedness and curiosity;
2. demonstrate independence of thought necessary for leadership and creativity;
3. pursue lifelong learning.

Interpersonal Relations

As part of education in grades K-12, each student should be able to:

1. develop productive and satisfying relationships with others based upon mutual respect;
2. develop a sensitivity to and an understanding of the needs, opinions, concerns and customs of others;
3. participate actively in reaching group decisions;
4. appreciate the roles and responsibilities of parents, children and families.

Sense of Community

As part of education in grades K-12, each student should be able to:

1. develop a sense of belonging to a group larger than friends, family and coworkers;
2. develop an understanding of the importance of each individual to the improvement of the quality of life for all in the community;
3. examine and assess the values, standards and traditions of the community;
4. understand and appreciate his/her own historical and ethnic heritage as well as that of others represented within the larger community.

Moral and Ethical Values

As part of education in grades K-12, each student should be able to:

1. recognize the necessity for moral and ethical conduct in a society;
2. recognize that values affect choices and conflicts;
3. develop personal criteria for making informed moral judgments and ethical decisions.

SKILLS AND COMPETENCIES

All educated citizens must possess a core of basic or enabling skills and competencies that provide the critical intellectual foundations for broader acquisition of knowledge. These enabling skills, applied in diverse ways, form the heart of an academic experience as each contributes to the development of understanding within and among disciplines.

Reading

As a result of education in grades K-12, each student should be able to:

1. identify and comprehend the main and subordinate ideas, details and facts in written work and summarize the ideas in his/her own words;
2. identify, comprehend and infer comparisons, contrasts, sequences and conclusions in written work;
3. recognize different purposes and methods of writing, identify a writer's point of view and tone, and interpret a writer's meaning inferentially as well as literally;
4. set purposes, ask questions and make predictions prior to and during reading and draw conclusions from reading;
5. make critical judgments about written work including separating fact from opinion, recognizing propaganda, stereotypes and statements of bias, recognizing inconsistency and judging the validity of evidence and sufficiency of support;
6. vary his/her reading speed and method based on the type of material and the purpose for reading;
7. use the features of books and other reference materials, such as table of contents, preface, introduction, titles and subtitles, index, glossary, appendix and bibliography.

Writing

As a result of education in grades K-12, each student should be able to:

1. write standard English sentences with correct sentence structure, verb forms, punctuation, capitalization, possessives, plural forms, word choice and spelling;
2. select, organize and relate ideas and develop them in coherent paragraphs;
3. organize sentences and paragraphs into a variety of forms and produce writing of an appropriate length using a variety of composition types;
4. use varying language, information, style and format appropriate to the purpose and the selected audience;

5. conceive ideas and select and use detailed examples, illustrations, evidence and logic to develop the topic;
6. gather information from primary and secondary sources; write a report using that information; quote, paraphrase and summarize accurately; and cite sources properly;
7. improve his or her own writing by restructuring, correcting errors and rewriting.

Speaking, Listening and Viewing

As a result of education in grades K-12, each student should be able to:

1. engage critically and constructively in an oral exchange of ideas;
2. ask and answer questions correctly and concisely;
3. understand spoken instructions and give spoken instructions to others;
4. distinguish relevant from irrelevant information and the intent from the details of an oral message;
5. identify and comprehend the main and subordinate ideas in speeches, discussions, audio and video presentations, and report accurately what has been presented;
6. comprehend verbal and nonverbal presentations at the literal, inferential and evaluative levels;
7. deliver oral presentations using a coherent sequence of thought, clarity of presentation, suitable vocabulary and length, and nonverbal communication appropriate for the purpose and audience.

Quantitative Skills

As a result of education in grades K-12, each student should be able to:

1. add, subtract, multiply and divide using whole numbers, decimals, fractions and integers;
2. make and use measurements in both traditional and metric units to measure lengths, areas, volumes, weights, temperatures and times;
3. use ratios, proportions and percents, powers and roots;
4. understand spatial relationships and the basic concepts of geometry;
5. make estimates and approximations, and judge the reasonableness of results;
6. understand the basic concepts of probability and statistics;
7. organize data into tables, charts and graphs, and read and interpret data presented in these forms;
8. formulate and solve problems in mathematical terms.

Reasoning and Problem Solving

As a result of education in grades K-12, each student should be able to:

1. recognize and use inductive and deductive reasoning, recognize fallacies and examine arguments from various points of view;
2. draw reasonable conclusions from information found in various sources, and defend his/her conclusions rationally;
3. formulate and test predictions and hypotheses based on appropriate data;
4. comprehend, develop and use concepts and generalizations;
5. identify cause and effect relationships;
6. identify and formulate problems;
7. gather, analyze, synthesize and evaluate information pertinent to the problem;
8. develop alternative solutions to problems, weigh relative risks and benefits, make logical decisions and verify results;
9. use critical and creative thinking skills to respond to unanticipated situations and recurring problems.

Learning Skills

As a result of education in grades K-12, each student should be able to:

1. set learning goals and priorities consistent with stated objectives and progress made, and allocate the time necessary to achieve them;
2. determine what is needed to accomplish a task and establish habits conducive to learning independently or with others;
3. follow a schedule that accounts for both short and long term project accomplishment;
4. locate and use a variety of sources of information including print and nonprint materials, computers and other technologies, interviews and direct observations;
5. read or listen to specific information and take effective and efficient notes.

UNDERSTANDINGS AND APPLICATIONS

Skills and competencies cannot be ends in themselves. Unless students have the knowledge and experiences needed to apply those learnings and develop a fuller understanding of life, their education will be incomplete. Schools must therefore accept responsibility for leading students through a body of knowledge and its application. This is what comprises the major content of the curriculum.

These understandings and applications have been grouped here under the usual disciplines, but it is important to recognize the inter-relationship among the disciplines and to promote students' ability to transfer knowledge and applications across subject areas.

The Arts: Creative and Performing

As a result of education in grades K-12, each student should be able to:

1. express his/her own concepts, ideas and emotions through one or more of the arts (art, music, drama and dance);
2. appreciate the importance of the arts in expressing and illuminating human experiences;
3. understand that personal beliefs and societal values influence art forms and styles;
4. identify the materials, processes and tools used in the production, exhibition and public performance of works of art, music, drama and dance;
5. use and understand language appropriate to each art form when discussing, critiquing and interpreting works in the visual and performing arts;
6. identify significant works and recognize the aesthetic qualities of art, music, drama and dance from different historical periods and cultures.

Careers and Vocations

As a result of education in grades K-12, each student should be able to:

1. demonstrate positive attitudes toward work, including acceptance of the necessity of making a living and an appreciation of the social value and dignity of work;
2. demonstrate attitudes and habits (such as pride in good workmanship, dependability and regular attendance) and the employability skills and specialized knowledge that will make the individual a productive participant in economic life and a contributor to society;
3. consider the range of occupations that will be personally satisfying and suitable to his/her skills, interests and aptitudes;
4. identify, continue or pursue the education and training necessary for his/her chosen career/vocation;
5. understand personal economics and its relationship to skills required for employment, promotion and financial independence;
6. exhibit the interpersonal skills necessary for success in the workplace (such as working harmoniously as part of a team, and giving and taking direction).

Vocational Education and the Common Core of Learning
HEALTH OCCUPATIONAL EDUCATION

Appendix B

See pages for the full text of each element listed in abbreviated form below.

RATING SCALE

A Element should be given a *major* focus
B Element should be given a *moderate* focus
C Element should be given a *minor* focus
D Element not traditionally a focus

	COURSE OFFERINGS					
	Intro. to H. Car.	Nurse Assistant	Allied Health	Med. Lab Asst.	VICA	
ATTRIBUTES AND ATTITUDES						
Positive Self-Concept						
1. Worth and Self-esteem	A	A	A	A	A	
2. Personal Effectiveness	A	A	A	A	A	
3. Understanding Strengths and Weaknesses	B	A	A	A	A	
Motivation and Persistence						
1. Pride of Accomplishment	B	A	A	A	A	
2. Desire to Succeed	A	A	A	A	A	
3. Tasks and Ambitions	B	A	A	A	A	
Responsibility and Self-Reliance						
1. Identify Needs and Set Goals	A	A	A	A	A	
2. Responsibility for Actions	A	A	A	A	A	
3. Dependability	B	A	A	A	A	
4. Self-Control	B	A	A	A	A	
Intellectual Curiosity						
1. Questioning Attitude	A	A	A	A	A	
2. Independence of Thought	A	A	A	A	A	
3. Lifelong Learning	A	A	A	A	A	
Interpersonal Relations						
1. Productive Relationships	A	A	A	A	A	
2. Concerns and Customs of Others	A	A	A	A	A	
3. Reach Group Decisions	A	A	A	A	A	
4. Roles and Responsibilities	A	A	A	A	A	
Sense of Community						
1. Belonging to a Group	A	A	A	A	A	
2. Quality of Life	A	A	A	A	A	
3. Values, Standards and Traditions	A	A	A	A	A	
4. Historical and Ethnic Heritage	A	A	A	A	A	
Moral and Ethical Values						
1. Moral and Ethical Conduct	A	A	A	A	A	
2. Values Affect Choices and Conflicts	A	A	A	A	A	
3. Moral Judgments and Ethical Decisions	A	A	A	A	A	
SKILLS AND COMPETENCIES						
Reading						
1. Main and Subordinate Ideas	A	A	A	A	B	
2. Comparisons, Contrasts, Sequences	A	A	A	A	B	
3. Meaning-Inferential, Literal	A	A	A	B	B	
4. Predictions, Questions, Conclusion	C	C	C	B	D	
5. Critical Judgments	C	C	C	B	D	
6. Varying Reading Speed and Method	C	C	C	A	D	
7. Features of Reference Materials	C	C	C	D	D	
Writing						
1. Sentence Structure	B	B	B	B	A	
2. Organize and Relate Ideas	A	A	A	A	A	
3. Sentences and Paragraphs	B	B	B	B	A	
4. Language Style and Format	A	A	A	A	A	
5. Conceive Ideas	C	C	C	C	A	
6. Gather Information	B	B	B	B	B	
7. Restructuring and Rewriting	C	C	C	C	A	
Speaking, Listening and Viewing						
1. Oral Exchange of Ideas	A	A	A	A	A	
2. Ask and Answer Questions	A	A	A	A	A	
3. Spoken Instructions	A	A	A	A	A	
4. Distinguish Relevant from Irrelevant	A	A	A	A	A	
5. Comprehend Ideas	B	B	B	B	B	
6. Verbal and Nonverbal Presentations	A	A	A	A	A	
7. Oral Presentations	A	A	A	A	A	
Quantitative Skills						
1. Add, Subtract, Multiply and Divide	B	B	B	A	B	
2. Use Measurements	C	C	C	A	D	
3. Ratios and Proportions	D	D	D	B	D	
4. Spatial Relationships	D	D	D	D	D	
5. Estimates and Approximations	B	B	B	C	D	
6. Probability and Statistics	D	D	D	D	B	
7. Tables, Charts and Graphs	B	B	B	A	D	
8. Solve Problems	D	D	D	A	D	
Reasoning and Problem Solving						
1. Inductive and Deductive	B	B	B	B	B	
2. Conclusions from Information	A	A	A	A	A	
3. Predictions and Hypotheses	C	C	C	A	C	
4. Concepts and Generalizations	A	A	A	A	A	
5. Cause and Effect Relationships	A	A	A	A	A	
6. Formulate Problems	A	A	A	A	A	
7. Information Pertinent to Problems	A	A	A	A	A	
8. Solutions to Problems	A	A	A	B	A	
9. Creative Thinking Skills	A	A	A	D	A	
Learning Skills						
1. Goals and Priorities	A	A	A	A	A	
2. Habits Conducive to Learning	A	A	A	A	A	
3. Short and Long Term Projects	A	A	A	A	A	
4. Sources of Information	A	A	A	A	A	
5. Note Taking	A	A	A	A	A	

	COURSE OFFERINGS					
	Intro. to H. Car.	Nurse Assistant	Allied Health	Med. Lab Asst.	VICA	
UNDERSTANDINGS AND APPLICATIONS						
The Arts: Creative and Performing						
1 Expressing Emotions	D	D	D	D	D	
2 Appreciate the Arts	D	D	D	D	D	
3 Art Forms and Style	D	D	D	D	D	
4 Materials and Tools	D	D	D	D	D	
5 Language of Each Art Form	D	D	D	D	D	
6 Aesthetic Qualities	D	D	D	D	D	
Careers and Vocations						
1 Positive Attitudes Toward Work	A	A	A	A	A	
2 Employability Skills	A	A	A	A	A	
3 Range of Occupations	A	A	A	A	A	
4 Education and Training	A	A	A	A	A	
5 Personal Economics	B	B	B	B	A	
6 Interpersonal Skills	A	A	A	A	A	
Cultures and Languages						
1 Common Characteristics	A	A	A	A	A	
2 Differences Among People	A	A	A	A	A	
3 Understanding Other Cultures	D	D	D	D	D	
4 Structure of Language	D	D	D	D	D	
5 Commonalities and Differences	C	C	C	C	C	
6 Foreign Language	D	D	D	D	D	
History and Social Sciences						
1 Connecticut, U.S. and World	D	D	D	D	A	
2 U.S. History and Government	D	D	D	D	A	
3 Economics	D	D	D	D	C	
4 Political and Economic System	D	D	D	D	B	
5 Disciplines of History	D	D	D	D	B	
6 World Geography	D	D	D	D	C	
7 Critical Thinking	A	A	A	A	A	
8 Pluralistic Society	D	D	D	D	B	
9 Mutual Dependence	D	D	D	D	A	
Literature						
1 Human Experiences	D	D	D	D	D	
2 Essential Elements	D	D	D	D	B	
3 Literary Masterpieces	D	D	D	D	D	
4 Symbolism, Allegory and Myth	D	D	D	D	D	
5 Literary Themes	D	D	D	D	A	
6 Literary Works	D	D	D	D	D	
7 Reading as Lifelong Pursuit	D	D	D	D	A	
Mathematics						
1 Expressing Quantifiable Ideas	D	D	D	B	D	
2 Problem Solving	D	D	D	B	D	
3 Consumer and Job-related Tasks	B	B	B	A	B	
4 Tools for Solving Problems	D	D	D	A	D	
5 Physical and Social Phenomena	D	D	D	B	D	
6 Using Numbers	D	B	B	A	D	
7 Algebraic and Geometric Concepts	D	D	D	B	D	
8 Statistical Concepts	D	D	D	A	D	
Physical Development and Health						
1 Growth and Development	A	A	A	B	A	
2 Physical Fitness	A	A	A	D	A	
3 Scientific Principals	A	A	A	B	A	
4 Social Development	A	A	A	D	A	
5 Elements of Nutrition	A	A	A	A	A	
6 Healthy Environment	A	A	A	D	A	
Science and Technology						
1 Basic Principles of the Science	A	A	A	A	D	
2 Natural Resources	B	A	A	A	A	
3 Solving Problems	D	D	D	B	D	
4 Natural Phenomena	B	A	A	A	D	
5 Laboratory Measuring	A	A	A	A	D	
6 Emerging Technologies	A	A	A	A	A	
7 Potential and Limitations	A	A	A	B	A	

LESSON PLAN: 72

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

EVALUATION ITEMS:

1. List two types of oxygen containers.

   a.

   b.

2. List two methods of administration of oxygen.

   a.

   b.

3. A client is receiving oxygen. The nurse assistant should do all of the following except: (Circle the letter of the correct answer.)

   a. Check to see that portable oxygen tanks are secure.
   b. Check tubing for kinks and disconnections.
   c. Make sure the client is not lying on the tubing.
   d. Change the flowmeter to what you feel is the right amount of oxygen the client is to receive.

4. Which of the following is a sign that the client is not getting enough oxygen? (Circle the letter of the correct answer.)

   a. Restlessness, anxious
   b. Dyspnea, cyanosis
   c. Dizziness or faintness
   d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

_____5. Using oil-based products near oxygen is dangerous.
_____6. The water level in the humidifying jar should be about 1/4 full.
_____7. The face mask should fit snugly on the face.
_____8. Oral hygiene should only be done after meals for the client receiving oxygen.
_____9. Check for any signs of irritation from the mask or cannula.
_____10. Never remove the face mask when it is in place.

MEMORANDUM OF AGREEMENT

This memorandum of agreement between the Health Assistant Program under the direction of the Board of Education and The , shall be a continuing agreement unless terminated under provisions provided. It may also be subject to modification or revision under the proper sections noted.

I. Definitions:

For the purpose of this agreement, the following words shall be defined as stated below:

A. High School -

B. Student - Students enrolled at High School, who are participating in a program with the aforementioned health care facilities, to gain knowledge and information regarding health care.

C. Clinical Hours - The hours which the students spend in the clincial areas, including pre and post conference time.

D. Health Assistant Instructors - Those persons assigned by the Board of Education, with the responsibility of training and supervising the student.

E. Assigned Patient Care Unit - Instructional unit that the student is assigned to, for the particular care of an individual patient.

II. The Health Assistant Program will be responsible for:

A. Proper identification and selection of students, male and female, who will have shown satisfactory evidence of those qualifications and aptitudes which are essential to training progress in this field.

B. Personal and general professional guidance of the students through a fully qualified and certified "Registered Nurse." This person will supervise and coordinate students and their activities under this cooperative vocational education agreement.

C. Attendance of students at the time and place specified by prior consultation, for the clinical experience.

2. Check electrical equipment (electric razor, heating pad, radio) outside of client's room to assure proper functioning. If a spark occurs from faulty equipment, it is much more likely to burn faster and easier due to the high O concentration.

3. Avoid use of oil-based products (Vaseline, A&D Ointment) near oxygen.

4. Avoid static electricity from synthetic or wool fabrics.

B. Check to see that portable oxygen tanks are secured with straps to prevent them from falling.

C. Check the oxygen gauge indicating the amount of oxygen left in the tank; notify the charge nurse if the supply is low.

D. Check the tubing for kinks and disconnections.

E. Check to see that the client is not lying on the tubing.

F. Check flowmeter on oxygen tank to make sure it is delivering the prescribed rate; DO NOT change the setting, report to the charge nurse immediately if it is not correct.

G. Check water level in humidifying jar; it should be high enough (2/3 full) so that it bubbles as oxygen goes through it. It should also appear clear--no particulate matter. If anything appears abnormal, report to charge nurse. (CD-2)

III. Comfort Measures

A. Check the elastic headband securing face mask or cannula in place to see that it is not too tight and causing pressure areas.

B. Check for irritation from the mask or cannula around the face and ears; pad pressure areas with cotton.

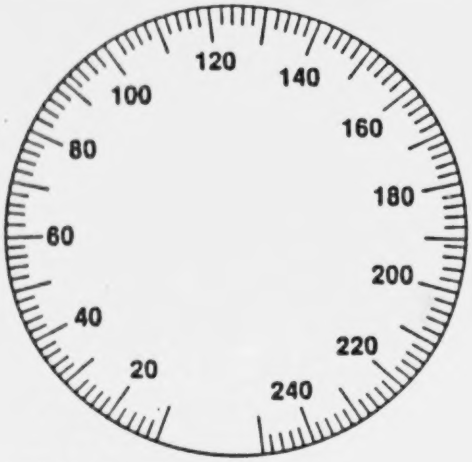
C. Keep the skin under cannula or mask clean and dry.

D. Give frequent oral hygiene and adequate fluids to the client; oxygen is drying to tissue, the mouth becomes dry and stale-tasting.

E. Remove and wipe face mask every shift to rid mask of moisture.

READING AN ANEROID SPHYGMOMANOMETER

Beside each sphygmomanometer gauge is a BP reading: the systolic and diastolic numbers. Mark the gauge by extending a line out from the correct systolic reading and a line out from the correct diastolic reading. Note: Each line on the gauge represents 2/10 mm. Hg.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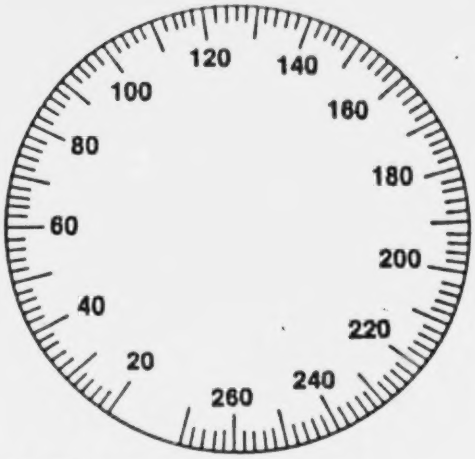
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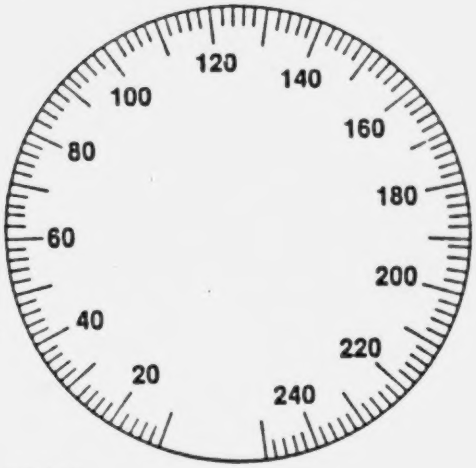
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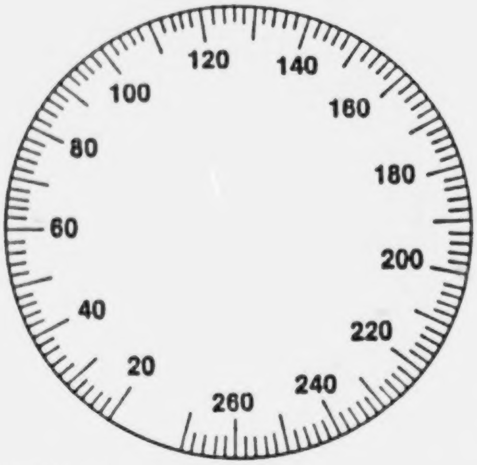
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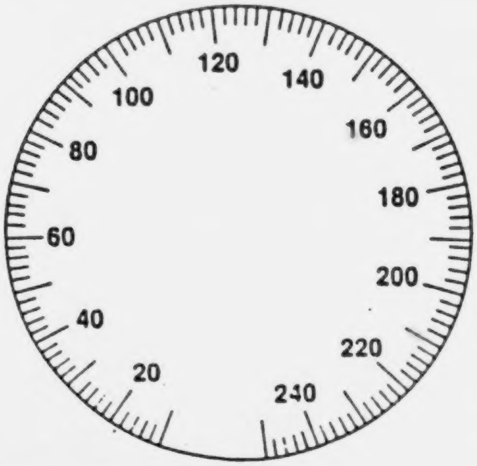
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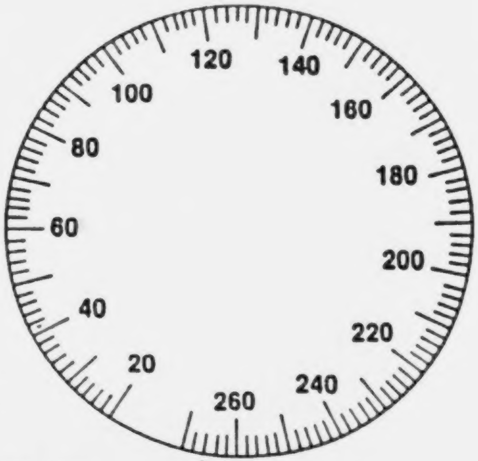
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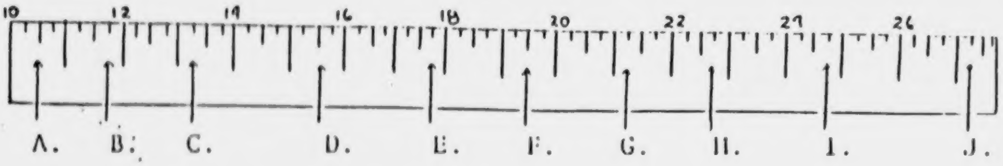
ANSWERS TO ASSIGNMENT SHEET, READ SCALE

Pink

If the large weight indicator is on 100, the client's weight would be 100 plus the weight indicated on the top scale bar.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A. 110½

B. 111 3/4

C. 113¼

D. 115½

E. 117 3/4

F. 119½

G. 121¼

H. 122 3/4

I. 124 3/4

J. 127¼

LESSON PLAN: 72

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

OUTLINE: (Key Points)

I. Oxygen Equipment

  A. Oxygen containers

    1. Oxygen cylinder or tank

    2. Central oxygen system with wall outlet connector

    3. Machines that remove oxygen from room air

  B. Methods of administration of oxygen (CD-1)

    1. Nasal cannula

      a. Two prongs leading from the tubing are placed in each nostril and held in place by an elastic strap around the head.

      b. Plastic tubing connects oxygen source container to the cannula.

      c. This is the most common device used to administer oxygen (O_2).

      d. Client should not breathe through mouth since the oxygen will go out the opened mouth.

    2. Mask

      a. Plastic mask placed over the nose and mouth and fitted to nose with metal adjuster

      b. Used for the client who is breathing through his/her mouth

      c. The most effective way of delivering oxygen

II. Safety Measures

  A. Oxygen speeds up combustion

    1. Post "No Smoking" signs when oxygen is set up.

LESSON PLAN: 72

COURSE TITLE: NURSE ASSISTANT

UNIT IX : SPECIAL PROCEDURES

ANSWERS TO EVALUATION ITEMS:

1. The student may list any two of the following:

   a. Oxygen cylinder or tank
   b. Central oxygen system with wall outlet connector
   c. Machines that remove oxygen from room air

2. a. Nasal cannula
   b. Mask

3. d

4. d

5. T

6. F

7. T

8. F

9. T

10. F

8026U

952

D. The clinical phase of training to begin not earlier than the last week of September of each school year; nor extend beyond the first week in June of said school year. Except that in the event of need and by mutual consent, special arrangements may be made.

III. The Health Assistant Instructor will:

A. Be a registered nurse currently licensed and certified to practice in the State of Connecticut and function as a representative of the school in those areas of this agreement which involve the regulations and standards of these health care facilities; as well as ensure that the high standards of education and training are maintained.

B. Instruct students as to the confidentiality of all information which may come to them in the course of patient care training.

C. Be responsible for all students, wherever located.

D. Supervise and control not more than six (6) students in a particular patient care unit.

IV. The student will:

A. Be responsible for the uniform, identification, and maintenance of the same.

B. Function as an observer only, in areas other than "Assigned Patient Care Units."

C. Have a physical examination prior to entering the clinical area.

D. Be in the clinical area on designated days for a total of at least sixty (60) hours practical experience for the school year.

E. Be withdrawn from the clinical phase until requalified, if not performing satisfactorily for whatever reasons.

V. The Health Care Facilities will be responsible for:

A. Allowing the Health Assistant Instructor to orient the students to the health care facility and its environs and services.

B. Providing a clinical environment for practical experiences for the student.

Cultures and Languages

As a result of education in grades K-12, each student should be able to:

1. recognize characteristics common to all people, such as physical attributes, emotional responses, attitudes, abilities and aspirations;
2. respect differences among people and recognize the pluralistic nature of United States society;
3. demonstrate an understanding of other cultures and their roles in international affairs;
4. analyze the structure of spoken and written language;
5. recognize the commonalities and the differences that exist in the structure of languages;
6. understand and communicate in at least one language in addition to English.

History and Social Sciences

As a result of education in grades K-12, each student should be able to:

1. recognize and analyze events, personalities, trends and beliefs that have shaped the history and culture of Connecticut, the United States and the world;
2. demonstrate a knowledge of United States history and government and understand the duties, reponsibilities and rights of United States citizenship;
3. understand the basic concepts of economics;
4. analyze and compare the political and economic beliefs and systems of the United States with those of other nations;
5. apply major concepts drawn from the disciplines of history and the social sciences — anthropology, economics, geography, law and government, philosophy, political science, psychology and sociology — to hypothetical and real situations;
6. demonstrate basic knowledge of world geography;
7. apply critical thinking skills and knowledge from history and the social sciences to the decision-making process and the analysis of controversial issues in order to understand the present and anticipate the future;
8. understand the roles played by various racial, ethnic and religious groups in developing the nation's pluralistic society;
9. appreciate the mutual dependence of all people in the world and understand that our lives are part of a global community joined by economic, social, cultural and civic concerns.

Literature

As a result of education in grades K-12, each student should be able to:

1. understand that literature reflects and illuminates human experiences, motives, conflicts and values;
2. understand the essential elements of poetry, drama, fiction and nonfiction;
3. understand and appreciate selected literary masterpieces, both past and present, that manifest different value systems and philosophies;
4. recognize symbolism, allegory and myth;
5. identify literary themes and their implications;
6. evaluate selected literary works and support each evaluation;
7. enjoy reading as a lifelong pursuit.

Mathematics

As a result of education in grades K-12, each student should be able to:

1. understand that mathematics is a means of expressing quantifiable ideas;
2. apply mathematical knowledge and skills to solve a broad array of quantitative, spatial and analytical problems;
3. use mathematical skills and techniques to complete consumer and job-related tasks;
4. select and use appropriate approaches and tools for solving problems, including mental computation, trial and error, paper and pencil, calculator and computer;
5. use mathematical operations in describing and analyzing physical and social phenomena;
6. demonstrate a quantitative sense by using numbers for counting, measuring, comparing, ordering, scaling, locating and coding;
7. apply basic algebraic and geometric concepts to representing, analyzing and solving problems;
8. use basic statistical concepts to draw conclusions from data.

Physical Development and Health

As a result of education in grades K-12, each student should be able to:

1. understand human growth and development, the functions of the body, human sexuality and the lifelong value of physical fitness;
2. plan and implement a physical fitness program with a variety of conditioning exercises and/or leisure activities;
3. understand the basic scientific principles which apply to human movement and physical activities;
4. understand the role physical activities play in psychological and social development;
5. understand and apply the basic elements of proper nutrition, avoidance of substance abuse, prevention and treatment of illness, and management of emotional stress;
6. recognize the need for a safe and healthy environment, practice proper safety skills, and demonstrate a variety of basic life saving skills.

Science and Technology

As a result of education in grades K-12, each student should be able to:

1. understand and apply the basic principles, concepts and language of biology, chemistry, physics, earth and space science;
2. understand the implications of limited natural resources, the study of ecology and the need for conservation;
3. identify and design techniques for recognizing and solving problems in science, including the development of hypotheses and the design of experiments to test them — the gathering of data, presenting them in appropriate formats, and drawing inferences based upon the results;
4. use observation and analysis of similarities and differences in the study of natural phenomena;
5. demonstrate the ability to work with laboratory measuring, manipulating and sensing devices;
6. understand the implications of existing and emerging technologies on our society and our quality of life, including personal, academic and work environments;
7. recognize the potential and the limitations of science and technology in solving societal problems.

C. Providing guidance and information to the instructor regarding changes in the health care facility procedures, policy and regulation that affects student instruction and training experience.

D. Assisting the instructor by an on-going sharing of information regarding the student's progress during the clinical practicing.

E. Providing notice to the instructor and the school in writing of any student's improper conduct.

F. Sharing a summary of the program's results for the year with the health care facility staff to provide for analysis, review and corrective recommendations, as applicable, to be considered and implemented in the subsequent school year.

G. Participating in the established Health Assistant Advisory Council, for purposes of evaluation of curriculum, or for any other reasons which would serve to promote a high quality program and better meet the needs of all parties to this agreement.

VI. Insurance

The Nursing Assistant Instructor and the Assistant Nursing Instructor will be responsible for the insurance coverage. The Board of Education will be responsible for insurance coverage of the students participating in the program to and from the Health Facility as per the attached letter.

VII. Termination

This agreement shall be terminated by mutual consent or by either party, in writing. Such termination shall be effective upon the close of the school year in which such a request is tendered. The year end effective date of any termination of this agreement will provide ample time for students to satisfactorily complete their training.

VIII. Students participating in the Nursing Assistant Program will be required to take the P.P.D. test.

________________________ Nursing Director

________________________ Director of Nursing-Health Director

________________________ Superintendent of Schools -

________________________ District Vocational Ed. Coordinator
Home Ec/Vocational/Industrial Arts

________________________ Nursing Assistant Instructor